HEALTH CARE COST AND ACCESS

HEARING

BEFORE THE

COMMITTEE ON THE BUDGET
HOUSE OF REPRESENTATIVES

ONE HUNDRED SECOND CONGRESS

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HEALTH CARE COST AND ACCESS

WEDNESDAY, JUNE 19, 1991

HOUSE OF REPRESENTATIVES,
COMMITTEE ON THE BUDGET,
Washington, DC.

The Committee met, pursuant to notice, at 9 a.m., in room 210, Cannon House Office Building, Hon. Leon E. Panetta, Chairman, presiding.

The CHAIRMAN. The House Budget Committee is in session for a hearing on health care and access issues.

This is one of a series of hearings, as many of you know, that we have held on long-term issues to try to prepare for the budget for next year and to try to focus on the rest of the nineties.

Health care is obviously the preeminent domestic issue of the nineties.

Costs, as we know, are rising rapidly and growing numbers of Americans do not have access to quality care.

Governments at all levels as well as families and individuals are facing a staggering burden in this area.

Even as the medical industry is able to do more and more to prevent illness to cure the sick and to unable people to live longer and healthier lives there is a growing gap between those with access to modern medical miracles and those who must struggle to meet the cost of a single visit to the doctor.

As a society, we pay more and more. In some ways, we receive more for our money, and in some ways less.

Costs continue to rise much faster than the overall rate of inflation.

We spend more on health care per capita and as a percentage of GNP than all other industrialized nations. Today, it represents about 12 percent of GNP. By the year 2000, just 9 years from now, it is expected to be over 15 percent of GNP. This is a huge budget problem for Government at all levels.

Public sector funds over 40 percent of total health care expenses, primarily for Medicare and Medicaid.

Congressional Budget Office projects that health care spending will take 20 percent of the Federal budget by 1996. What do we receive for that?

In most instances, those with access to care are receiving quicker and more accurate diagnoses and better care.

As we all know, there is a gap that involves about 33 million Americans under the age of 65. Most could be classified as working poor, without any private health insurance or public coverage.

These people, a third of whom are children, simply lack access to health care because of the high cost of treatment.

In addition, there may be 65 to almost 70 million more Americans who are underinsured with inadequate coverage for basic health care.

This patient is ready for radical surge, and at least 17 of our colleagues have made proposals for far-reaching changes in our health care system.

Five of them will testify this morning, and we are looking forward to hearing their ideas.

They are Senate Majority Leader Mitchell, Chairman of our two health Subcommittees, Henry Waxman, Pete Stark, Nancy Johnson, and Marty Russo.

We will later have a panel who will discuss the situation from their point of view and their proposed solutions.

The next witness, Humphrey Taylor, the head of the Louis Harris & Associates firm, will discuss public attitudes toward the issue and toward some of the broad changes that have been suggested.

Finally, we will have a panel that will discuss the innovative approaches that have been taken by some States from rationing of health care to nearly universal health care coverage. We will also address the critical issue of long-term health care.

I want to inform the Members that with this full plate of witnesses today, the Chair will adhere to the 5-minute rule as we proceed, because we have a number of witnesses. Mr. Gradison.

Mr. GRADISON. Thank you, Mr. Chairman.

I want to join with you and associate myself with your remarks regarding to the importance of the issues that we are going to be discussing here today.

Clearly, we have an unsustainable situation with regard to the health care system in the United States. The problems involve the delivery system as well as the financing, although those are two separate issues.

I think we are making some progress in thinking through what the appropriate response to this emerging crisis.

There seems to be a growing consensus that our initial concerns should be about cost and access.

There are other things that might be put on the list, but I think that focus is developing.

My own view, however, is that we are far from agreement on the next point, which is what the options are.

In this regard, I want to congratulate all the groups—public and private, in both parties, in and out of Government—who have gone through the exercise of trying to pull together their recommendations and putting a specific plan on the table. I know how hard that is to do.

I may or may not agree with the specifics, but I think we are at a stage where we are trying to think this thing through as a Nation, where we are trying to get away from the generalities and get into the specifics: What would the plan cover? How will it be financed?

In that regard, the recent initiatives by the Democratic Party and the U.S. Senate are to be applauded. I don't happen to agree

with their conclusions, but I think the fact they have gone through the effort moves this debate forward.

I also would say that, at least from my observation, we have to give a lot more thought to the question of who is responsible for dealing with this issue in the future.

Is it the individual, if he or she is able to afford it? Is it the employer? Is it Government? If so, which level of Government? If it is all of the above, how are those burdens to be shared?

That is really a different question. My personal hunch is that we are going to spend most of the decade of the nineties trying to think our way through it.

In any event, Mr. Chairman, I am particularly pleased to see this hearing scheduled.

As you know, Mr. Chairman, the health care issue has been a matter of concern among all Members of the Budget Committee, on both sides of the aisle, and your arranging for such a comprehensive hearing is much appreciated by our side.

The CHAIRMAN. Thank you very much.

Our first witness, Henry Waxman, who is obviously not only the Chairman of a very important Subcommittee on Health and the Environment of Energy and Commerce, but I think all of us know he is a leader in the health care area, not only in terms of the quality of health care, but ensuring that our most vulnerable citizens have access to that health care.

I don't know what the ultimate answer will be in this issue, but you can bet that Mr. Waxman will play a role in whatever that final design looks like. For that reason, we welcome you here to the Budget Committee.

Your statement will be made part of the record.

STATEMENT OF HON. HENRY A. WAXMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA; AND CHAIRMAN, SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT OF THE COMMITTEE ON ENERGY AND COMMERCE

Mr. WAXMAN. Thank you very much.

I am pleased to be here with you to discuss this issue and I commend you for taking up this question, which is a perplexing one, and yet one I think we need to tackle head on and no longer push to the sidelines.

Recently, Senator Rockefeller and I introduced the legislation of the Pepper Commission.

I know you will be hearing shortly from Senator Mitchell as well as our colleague in the House, Mr. Stark, who has his own initiative.

My Committee, along with the Ways and Means and Education and Labor Committees, is working with the House leadership to develop an initiative that House Democrats can sponsor.

Only the Bush Administration doesn't seem to see the urgency of the problem.

In his State of the Union message just 5 months ago, President Bush said, "Good health care is every American's right."

Unfortunately, there are millions of Americans who, unlike the President and Members of Congress do not have access to good health care.

Yet, the Secretary of Health and Human Services has spent the last few months telling audiences around the country just what the Administration is against, which includes all of the reform proposals you will hear about this morning.

We still have no clue what, if anything, the Administration is for, other than personal responsibility and malpractice reform.

I have been asked to outline the Pepper Commission approach.

Attached to my testimony is a short summary of the House version, H.R. 2535, which I introduced earlier this month.

Under this bill, all Americans would have coverage for basic health care—preventive, hospital, and physician services—in one of three ways: Through their employers; through a new, federally run public plan; or, in the case of the elderly and disabled, through Medicare.

Large and medium-sized employers would be required to assure that all full-time employees and dependents have coverage for basic health services.

Employers could meet this obligation either by offering private coverage or by enrolling their employees in the new public program for a premium set at a fixed percent of payroll.

Unlike an employer "mandate," under which employers would be required to purchase private insurance coverage for their employees and dependents regardless of cost, this play or pay approach guarantees employers that their financial exposure is limited to a fixed percent of payroll.

At the same time, if the employer premium level is set high enough, the "play or pay" does not create an incentive for most employers to move their employees into the public plan, keeping on-budget costs down.

To control private and public health care spending, our bill does several things:

First, it creates incentives for consumers to be cost-conscious by subjecting all of the basic health services other than preventive care to deductibles of $250 per individual and $500 per family, and by imposing a 20-percent coinsurance obligation.

Low-income people would give assistance in meeting these cost-sharing requirements.

Second, the bill gives employers, insurers, labor-management funds, and other private purchasers the option to use public plan rates in paying for hospital, physician, and other basic health care services.

The public plan will pay for basic health services using Medicare principles.

Finally, the bill creates incentives for the use of managed care, preempts State minimum benefits laws, and directs the development and use of clinical practice guidelines.

Although the bill will help restrain health care costs, it will still require significant additional Federal funds.

I don't yet know exactly how much, but I have requested estimates from both CBO and OMB.

Some of these costs would be paid for by the premium contributions made to the public plan by employers who choose to "pay" and by individuals outside the work force who choose to enroll.

My proposal for the rest of the financing needed to keep the public program on a pay-as-you-go basis would be a surtax on individual and corporate income tax liability.

The exact amount of the surtax would be set once estimates of the public program costs are available.

I suggest this surtax because it is simple to administer and understand, broad-based, moderately progressive, and is likely to grow over time.

I recognize that there are other potential revenue sources that the Committees of jurisdiction may wish to use instead.

The important point is that the public program be given a revenue source that is stable and avoids the chronic underfinancing that plagues the Medicaid program. In closing, I want to make four points.

First, the way we pay for health care in this country is fundamentally flawed. The system is broken and it needs to be fixed.

Leaving things alone won't solve the problem. Instead, costs will continue to climb, and more Americans will become uninsured or underinsured. For millions of Americans, access to basic health care services will be threatened.

Second, the longer we wait to begin to solve this problem, the more expensive the solution will be.

Health care costs are projected to grow at least 12 percent per year over the next few years.

At this rate, to assure that all Americans have access to a basic package of services will cost 57 percent more in 1995 than it would cost today and 147 percent more in the year 2000 than it would cost today.

Third, even with effective cost controls, health care reform will not be budget-neutral.

No one disputes that there are substantial savings to be had from eliminating inappropriate care, reducing administrative overhead, and other system reforms.

But these savings will not be sufficient to supply all of the additional resources needed to assure that all Americans have coverage for basic health care services. The numbers of uninsured and underinsured Americans is simply too large.

My final point is that if we are serious about giving all Americans coverage for basic health care services, there are really only two roads to reform.

One is to build on the existing employment-based health insurance system, as the Pepper Commission bill and Senator Mitchell's proposal would do.

The other is to phase out the current private health insurance system and replace it with Medicare, as Mr. Stark's bill would do, or with a new public health insurance program, as Mr. Dingell's bill or Mr. Russo's bill or Ms. Oakar's bill would do.

The road we must avoid is the one which looks to each State to develop its own solution to paying for basic health services.

The Medicaid program teaches us that State revenue growth cannot, over time, keep pace with the costs of providing basic

health care services, even where drastic cost controls—such as limiting covered hospital days to 18 per year—are used.

If States are given a major role in financing health care services, they will insist on "flexibility" to control their expenditures by limiting benefits, lowering reimbursement, or reducing eligibility.

I believe that all Americans, whether they live in California or Maine or Texas or Tennessee, should be entitled to coverage for basic health services.

I look forward to working with you and the Members of this Committee to design and fund a program that will achieve this goal as soon as possible.

The CHAIRMAN. Thank you very much, Mr. Waxman, again for taking the time to come and give the benefit of your views on this issue.

Could I ask, with regard to your particular proposal, what you estimate the cost of your proposal to be in the first year, and perhaps over the next 5 years so we get some sense of the cost?

Mr. WAXMAN. We are asking CBO to give us an estimate, but we don't have those yet.

The Commission estimated it would cost the Government about $24 billion per year when it is fully implemented, and the way the bill is designed is that expenses would be phased in over 5 years, but that is the best we can give you by way of a dollar figure at this time.

The CHAIRMAN. Mr. Waxman, one of the debates going on is the debate of whether we should take an incremental approach and work with the existing system or whether we ought to do a full-scale reform.

Evidently, GAO kind of suggested in their testimony we might save more money if we go to a full-scale, single payer approach. What is your view on this?

Mr. WAXMAN. I think it is a mistake not to call this a full-scale reform, because I think it is a full-scale reform.

It is a reform brought about by building on the existing system rather than scrapping the existing system and starting all over.

I have deep misgivings about the idea of the Federal Government taking over the health care system of everyone in this Nation. I do believe in many ways it could be a lot more efficient.

It could reduce costs, but I am not sure the quality of care or the satisfaction of people in this country will be there if the Federal Government runs it.

I must tell you that the Federal Government does not have a terrific track record in running some of these programs to the point where we would feel comfortable that it all ought to be publicly administered.

I think as well it is politically nonviable to talk about scrapping the existing system.

I think a lot of people might find it attractive because they are not thinking the issue through, but I think a lot of people would like to have the Federal Government make sure they have health insurance at no extra cost to them and someone else will pay the billion. It doesn't quite work out that way.

There are ways to use this employer-based public program system combination to bring about some of the reforms that seem attractive in a single-payer system.

If there are multiple payers, those multiple payers can be coordinated in terms of their payments toward provided care in a way that will hold down cost.

Some analysts have even suggested multiple-payers can pay into a single payer that would then disburse the funds to the various providers of care to get the full benefits of what is called a single benefit system.

I don't think we need a radical reform, nor do I think it is desirable, of having the Federal Government take over health care in this Nation in order to bring about the major reforms that we need, which are to make sure that everyone has access to care and to hold down the cost of care for those who do have insurance.

The CHAIRMAN. On the issue of when such a reform, whether it is your approach or others, might, in fact, occur, what is your view?

Is it something that has to be part of the debate next year before we take any action? Is that your sense as well?

Mr. WAXMAN. My sense is that we ought to start grappling with the issue of setting in place legislation to phase in the reform of our health care system. I think we have various competing proposals.

We ought to try to see if they can be reconciled. We need to get the Members of Congress not just to debate the issue in an abstract way—we have been doing that for 30 years—but to start grappling with the details of this legislation or something like it and make fundamental decisions.

We need an educational effort so people understand what is at stake. That would be far more desirable if we had a President who would undertake that educational effort.

But since the Administration is not taking this on as an important priority, then Congress should take on this effort of educating the public and starting to make the fundamental decisions and tradeoffs to try to get this reform moving.

The CHAIRMAN. Have you had discussions with Administration officials about the various reform proposals?

Mr. WAXMAN. I really have not. I am available.

The CHAIRMAN. You have no sense of where the Administration would be on the proposals offered the Congress?

Mr. WAXMAN. All we know is statements from the Administration that they are against increasing Medicaid or an employer-based system or the Canadian system. We know what they are against, but no idea what they are for. They have set up study groups to make recommendations, which we are all awaiting.

The CHAIRMAN. Mr. Gradison.

Mr. GRADISON. Thank you, Mr. Chairman.

I think it is kind of a cheap shot, frankly, to say, "If the President only got on board, these things would happen."

Presidents of both parties have tried to do these things over the years—without success.

The idea of an employer mandate came from Richard Nixon. It was not unlike your proposal, actually.

People said it wasn't enough, it wasn't comprehensive enough. It didn't happen.

President Carter got elected on a platform that endorsed—and he endorsed— comprehensive national health insurance. He became President and said, "Until we get costs under control, we shouldn't move ahead with this."

I really don't want to inject an air of partisanship into this. But I want to indicate that this issue is far more complicated than saying if the President would only do it, it would happen.

A lot of Presidents as far back as Franklin Roosevelt and Harry Truman have tried to move this Nation in the area of health care. In certain respects, I am glad they failed.

The point is they tried, but couldn't move the system. There were other things going on.

I want to congratulate our colleague from California on the leadership he has given in the health care field, and I particularly want to call attention to two points he made that are often glossed over.

The first is that it is going to cost money. The GAO makes it sound as if this thing is going to come free. I don't happen to believe that. I gather the gentleman from California isn't sure about that either.

Recognizing it is going to cost money and putting a specific financing proposal on the table moves the debate forward. I congratulate the gentleman for that.

I also appreciate and agree with the reservations he has expressed about whether in the end the Federal plan will be the best.

When I look at the Federal involvement that we have had over the years—and in particular two health care programs that have been totally federally controlled, as far back as 200 years or so, the Veterans' Administration and the Indian Health Service—I have to ask myself: Is that the model we want for the country as a whole?

Raising that question is not to criticize these services. They have budget problems at the Federal level as well as the other levels. This calls into serious question the notion that if the Feds get into it, there will be adequate money.

I guess my principle question--I do have a question for the gentleman—is why he appears to be hostile to the idea of States developing their own plans.

The percent of uninsured varies enormously from State to State. California has about 20 percent; Texas about 25 percent. The ability of an individual State to cope with this—and to cope with it soon—would seem to me to be there, at least once this economy turns around.

I am troubled by the idea that we should in any way discourage a State from doing what it wants to do. I don't happen to think the Massachusetts plan is one I want for the country as a whole, but I hope they give it a try, to see if it works.

I was visited by the Health Commissioner in the State of Hawaii, and they have had a pay-or-play plan since 1984. Their message was, whatever you do in Washington doesn't stop us from doing what we are doing in Hawaii. That is a very important message. I am not sure why that shouldn't apply to California as well.

Mr. WAXMAN. I guess the point should be perhaps that I shouldn't criticize any chief executive who is trying to do something.

In defense of my chief point about the Administration, we have had Presidents try, and this issue is enormously complex. I don't see this Administration trying at all, and the problem is much worse and going to get worse.

My hesitation about States undertaking this effort is that States vary in terms of their ability—not only of the amount of the problem, but their ability to deal with the problem.

The model I have seen for variations between the States is the way they handle the Medicaid program.

I just am troubled by the idea that in one State a child will have a chance for health care as defined through a more generous Medicaid package, but in another State, a more stringent Medicaid package is available and a child born to a poor family wouldn't have a change for good health care in the beginning. So I think there ought to be some kind of basic uniformity.

I look at what is being proposed in a place like Oregon, and I find that troubling, that they would set up a rationing system by opposing rationing on the lowest income, the most vulnerable population.

But I have to say to you that while I prefer it not be done at the State level, I may out of frustration think that is the route we ought to take, although I think it is going to be a lot more different and our problems are going to be multiplied if we have too many variations of how States handle the problem.

Mr. GRADISON. Let me ask a very direct question. You may not be in a position to answer it, but if your own State were moving toward a California solution in the next couple of years, would you, in principle, object to their doing that because it might slow down movement to a Federal system?

Mr. WAXMAN. I would prefer that we have a Federal solution to this problem, but if we are not going to make any headway, then I would be more sympathetic to my own State and other States trying to act on their own.

That would require some important changes in Federal law, especially in the area of ERISA health care coverage, to allow the States to reach those plans.

We would have to rethink how Medicaid will operate and I would still like to see some standardization around the country of Medicaid, even if States run their own health insurance and build on that as one of the components for their public program.

I would strongly prefer we handle this at the Federal level. To me it makes so much more sense, but I am not going to say I am adamant on it.

The CHAIRMAN. The time of the gentleman has expired. Mr. Guarini.

Mr. GUARINI. Thank you very much, Mr. Chairman.

I wish you luck in your endeavors because this is a matter in which the country must deal with before the health care services are completely out of control.

Do I understand you correctly, that the payment should be through the employers, but the Administration and management of the program should be through the Federal Government?

Mr. WAXMAN. No. My suggestion, based on this Pepper Commission recommendation, is that since most people have their insurance through their jobs at the present time, and since two-thirds of the uninsured in this country are working people or their dependents, that rather than have the Federal Government take over the whole health care system, we build on the employer basis that we now have and use a public program at the Federal level for those who are not going to be covered through their jobs.

Now, the insurance that would be available to employees and their dependents would be in effective a—minimum benefits would be spelled out, both for the public and the private plans, but others, it would be pretty much the existing system, where employers, employees can purchase a private insurance plan for those that would be covered.

Mr. GUARINI. But there is nothing about catastrophic or long-term care or anything resembling such care?

Mr. WAXMAN. Long-term care is another issue which is important to discuss, but I was talking now about the access to acute care and how we can get that available.

The Pepper Commission did make a recommendation on long-term care, and I will be introducing legislation to set that out in place as well.

I think they have a very sound proposal for long-term care, and that would be another expensive proposition for the Federal Government, one that is long overdue, to keep the proposal to the elderly and disabled in this country, not to leave them uncovered when they need attention for chromic——

Mr. GUARINI. So you would keep in place Medicaid and Medicare and build on those two systems?

Mr. WAXMAN. I would replace the Medicaid system. I would leave Medicare in place.

I would replace the Medicaid system with a broader public program that would not be tied to welfare.

Mr. GUARINI. Is there any prototype of the program you are suggesting in Europe or any industrialized nation that has experience from which we can draw and learn?

Mr. WAXMAN. I don't want to draw parallels too carefully.

I know there are a number of systems around the world that have been based on employer systems, Japan, Germany, Korea, all have built their national health insurance programs using employer-based systems. But I think what we end up with would be a uniquely American system.

If we were doing a health care system from scratch, I don't think we would design it this way, but since we already have a system that has evolved through the employer-employee relationship, I think it makes more sense to build on it and to put in some system that filled in the cracks and seal up the problems.

Mr. GUARINI. Some of the nagging questions that have really driven the costs of health care through the ceiling have been questions pertaining to malpractice, administration, and paperwork as

well as questions regarding the the high costs of equipment and pharmaceuticals.

Those are the kind of issues that really have driven health care costs out of control, according to some people. How does your program address these problems?

Mr. WAXMAN. Those are different problems. We are hoping to deal with them in a number of ways.

One, some of the initiatives the Congress has enacted that Mr. Gradison has been instrumental in authoring, set up research into appropriate practice patterns, will be helpful for us to know what is the appropriate care to be given.

Right now, we have tremendous variations around the country for which we get reimbursement in terms of the level of care, amount of care, and amount of services.

This will help us deal with technology, the best use of burgeoning technology, which is driving up health care costs.

The malpractice problem is a very real one, and I think we need to deal with it in the context of this type of legislation, although I must say that there are two aspects of that problem.

One is the premiums for malpractice insurance; and the model held up for malpractice reform in the California law. That has held down the cost of malpractice premiums for the providers of care.

The other side of the problem is the kind of care that is given in practice. I am not sure that has made a difference in the defensive medicine.

A lot of what is called defensive medicine, I think, is medicine that is practiced because technology is there and there is a third party to pay for it, as opposed to just simply a fear of lawsuits.

So the problem is a lot more complex, and it is the orientation of the health care providers to use whatever is available.

That is why those practice pattern guidelines, I think, will be so important as we try to figure out what the appropriate level of care is.

Mr. GUARINI. Mr. Chair, one last question. Does your package include and address the question of abuses and excesses in our health care system?

Mr. WAXMAN. It would build on what we would develop in the Medicare area, and apply it to private insurance, and we are at an early stage in developing the answer to these problems.

Mr. GUARINI. Thank you.

The CHAIRMAN. Mr. McMillan.

Mr. MCMILLAN. Thank you, Mr. Chairman, and thank you, Mr. Waxman, for coming over this morning. I have an opening statement. I would like unanimous consent to insert it in the record.

The CHAIRMAN. Without objection, it will be made part of the record.

[The opening statement of Mr. McMillan follows:]

OPENING STATEMENT OF HON. J. ALEX MCMILLAN

I don't want to take a lot of time from our distinguished colleagues and experts assembled here today nor do I want to seem to be repetitious in my comments about the state of health care in America today.

But I do want to let our panelists know that I am intensely eager to hear from them how the inherent factors that are driving up health care costs can be reduced

from within the existing system rather than only focusing on ways we can spend more money at the margins. Our problem is both cost and accessibility. To focus only on needs would be an unmitigated disaster, in my opinion, primarily because we have a window opportunity to make structural reforms at the heart of the matter that can and will deflate the medical cost balloon. The key to meeting unmet lies in controlling unnecessary costs.

I want to hear the thoughts of our colleagues and panelists on how we can arrest the rising costs due to defensive medical practices, malpractice insurance, excessive overhead, excess capacity, purchase of new technology at the expense of amortized equipment, and yes, the cost of attending the needs of the terminally ill. To cast about plans for universal health insurance or "play or pay" mandates without touching any of the underlying cost-drivers that are wilting the ability of the American medical community to continue to provide the high level of health we have come to expect in this country, would be a travesty at worst and Pollyanna-ish at best.

I hope the people assembled here today can give us helpful insight into solving in a creative way what I believe has become America's number one public policy problem. If we just gloss over the issue of health care by saying we need to spend more when the United States is already the highest per capita health spender in the world and do nothing to fix the delivery and distribution channels in our health care system, we will have totally failed to accomplish the right thing for the country.

Mr. McMillan. Just one comment on the politics of the thing. I think the gentleman from Ohio has recited a little history that is instructive. I think we all recognize that we are at a very different crossroads than we faced before with respect to medical care, and the opportunity exists here to address this issue overriding partisan considerations, because the problem is so excruciating that it is turning some people who have been liberal on the issue into conservatives, and vice versa.

And I think that creates an opportunity. I tend to favor those who view the challenge as one of addressing it comprehensively, because I think simply dealing with it in an add-on, marginal fashion is simply going to produce more of the same and not resolve the causes of the problem.

My colleague from New York, Mr. Guarini, raised some of the questions with respect to the element of cost, and I start from the proposition that we are spending probably 20 percent more per capita than the next highest nation in the world, which is Canada, which many use as a parity of what we should become.

If that is the case, and I don't necessarily buy that argument—and we are spending 20 percent more per capita—we are perhaps devoting resources, private and public, to medical care that might meet most of the unmet needs that exist out there.

I don't know that that is true. But I think that what we should do should be given that as at least a possibility so that we, along with addressing the unmet needs, at the same time address the factors that are driving costs out of control.

We have talked about them, we talked about them this morning. But I think it is absolutely essential that we make the resolution of those problems part and parcel of the solution, because there lies the wherewithal financially to deal with it.

We have had testimony in here, some of it is disputed, but defensive health care cost may be as much as $150 billion a year. Admittedly, it is difficult to define. You made a very good point. Some of it may not be done simply to avoid or provide a basis of evidence on the case of future liability.

Some of it is done just because it is there, like a lady who went into the hospital in my district with a headache and she gets CAT scan, and we all get billed $1,000. No one said take a couple of aspirin and come back tomorrow, and we will see if your headache has persisted.

We need to bring those things out. And if, in fact, it is as high as 20 percent, which some hospitals will tell you is the case, then that is an enormous amount of resources that are available to meet unmet needs. We have had a study done that indicates that the overhead of the system is in the neighborhood of $100 billion a year.

Well, the manner in which we address these questions has a lot to do with the level of that overhead, because we basically built an adversarial claims system, whether it is private or public, and there are other ways to go about that that can dramatically reduce the amount of that overhead. That should be considered.

We have allowed a system to develop that has redundant systems, both in terms of staff and fiscal capacity. And our antitrust laws often prohibit coordination that might reduce some of that within given communities.

That needs to be addressed. We have had testimony here that 50 percent of Medicare benefit payments this year will go to 5 percent of the beneficiaries in the last 5 months of life. No one wants to deny anyone whatever chance they have to make a significant improvement in their condition.

But there are a lot of terminal health care costs that don't. We have no system of ethics in place to deal with that in an honest fashion. So, I would simply throw that out as a general challenge that I am willing to try to abide by as we wrestle with this, to take these factors into account in whatever we do.

And we will probably disagree on the solution, but whatever we do, let's deal with the things that are driving these costs out of control. And if we deal with those successfully, we are going to find our solution is going to be much more easy to come by, and maybe at no incremental cost.

The CHAIRMAN. The time of the gentleman has expired, but if you would like to respond——

Mr. WAXMAN. I think you have raised a lot of good points. We need to figure out how to reduce the unnecessary costs in our health care system, the unnecessary expenditures.

I don't think there are easy answers to it. That is why I am skeptical of the GAO report and others who say that we don't have to spend any more money if we can only wring out the unnecessary costs in the existing system. We need to try to accomplish that.

I don't think we have a way to do it. I don't think we have a clear idea how to do it at this point. The point that I would reject is that the only way to do that is to have the Federal Government take over the health care system, because I don't know that the Federal Government particularly is the most effective agency in accomplishing the efficiency.

I appreciate your point about these are not partisan issues, they are bipartisan. We work together, liberals become conservatives, conservatives liberal; I have a feeling you have moved to my left on

this issue, as you described perhaps finding Government-run health insurance more attractive.

I guess all that points out is, we have got to think through together how to reduce the costs in the system that are not well-spent, without destroying the quality of care or the access to care, and how we do it is going to require the best minds of Democrats and Republicans.

And my goading of the Administration is to try to get them involved, because without their involvement, they have very little chance of us accomplishing what we need to accomplish for the national good.

I welcome the opportunity to work with you on our own Committee as well as the Budget Committee on these issues.

The CHAIRMAN. Mr. Spratt.

Mr. SPRATT. I have no further questions to ask you, except for one clarification. Is the public insurance plan you are providing one and the same with Medicaid?

Mr. WAXMAN. It would replace Medicaid, and Medicaid would be part of this public program. The public program ultimately would be a program that employers would pay their employees into if they chose to do that, and we cover those who are not working for whatever reason, and would then be covered by the public program.

Mr. SPRATT. And the State share of the Medicaid program would be phased out?

Mr. WAXMAN. I think it ought to be—yes, that would be my choice, although there are differences in opinion. That is a difference of opinion I had with the Pepper Commission.

Mr. SPRATT. So, when you give an estimate of $24 billion, does that include the Federal Government's assumption of the cost of the State share?

Mr. WAXMAN. I think that $24 billion has an assumption that the States will continue to pay the share that they are now paying of the cost for the public program, and so it is indexed at the level at which they are now paying for the future, so they would still be participating in the financing of that.

At some point, I would like to see the State costs phased out and have the States take more of a role in paying for the long-term costs.

Mr. GUARINI. How much money are we talking about? The State share in Texas of Medicaid is 50–50. Medicaid alone is somewhere in the vicinity of $100 billion. What is the figure?

Mr. WAXMAN. $39 billion for Federal and State, $25 billion of which would be State cost. Rather than shift the $25 billion on—to the Federal Government, we would continue to have the States participate in paying for that public program at the level at which they are now paying.

Mr. GUARINI. Thank you.

Mr. SPRATT. So, the $25 billion is additive to the $24 billion?

Mr. WAXMAN. For all public expenditures, State and Federal.

Mr. SPRATT. What would be the public percentage, the notional percentage you have in mind now for the subsidy for the public health plan?

In other words, the employer will pay certain percentage of the cost through enrolling his employee in the plan, what would the Federal subsidy be?

Mr. WAXMAN. We haven't got an official estimate, but what respect is a $24 billion Federal cost to pay for the—our share of that public program. Some of it, of course, will be paid for by employers who buy their people into that public program, and some will be paid for by State contributions.

Mr. SPRATT. Do you start out the program with a dollar amount rather than a percentage of total cost? In other words, is the Federal share fixed at $24 billion and then indexed to increase, or is it some total percentage of the program cost?

Mr. WAXMAN. First of all, I am uneasy using the $25 billion figure. That was the Commission's estimate, but we are waiting for a more official estimate of the Federal cost. That Federal cost is going to have to be determined after we get the balance between what the payroll tax level would be that would draw the right balance between employers deciding to enroll their people into a public plan as opposed to buying private insurance for them.

There has to be some balance, so you don't give incentives to employers to drop their insurance and have employees go into the public plan.

Mr. SPRATT. But it won't be a prescriptive percentage, for example, 25 percent would be the Federal share?

Mr. WAXMAN. No, it is not that.

Mr. GUARINI. Mr. Chairman, I would like to insert in the record CBO figures for the 1991 Federal outlays, which are: $50.8 billion on Medicaid; State outlays, $38.3 billion, which is a total of $94.1 billion, closer to the $100 billion than I thought it was.

Mr. WAXMAN. That total would include, I think, nursing home costs which would not be covered under the acute care program.

Mr. GUARINI. Those are Medicaid costs.

Mr. WAXMAN. Half of Medicaid now does for nursing home costs.

Mr. GUARINI. But the total cost of Medicaid to the States is $38.3 billion, and the total cost to the Federal Government on the Medicaid program is $50.8 billion, and just as a footnote, the annual rate of growth this year is listed at 23.7 percent. I just thought the record should reflect that. Thank you.

The CHAIRMAN. Mr. McCrery.

Mr. MCCRERY. I have no questions, Mr. Chairman.

The CHAIRMAN. Mr. Stenholm.

Mr. STENHOLM. Mr. Waxman, explain the term pay or play.

Mr. WAXMAN. An employer would either provide private health insurance for their employees, which would probably be the route that the larger employer would take, or they would pay into a fund to cover their employees in this public program. And that would be a fixed amount based on a payroll tax.

They would know the maximum level of their costs to go into a public program, and that would be the incentive, one way or the other, either to put their people on the public program or to provide private insurance for those employees.

Mr. STENHOLM. So "play" really means do it yourself; "pay" means participate in the Government program, "play" means private coverage? Is that what it basically means?

Mr. WAXMAN. Yes.

Mr. STENHOLM. Also, I am a little curious on your rationale. You seem, in this case, to be saying that the States should not be free to provide different plans, that the Federal Government ought to do it, another area where we have been disagreeing, or I find myself in agreement with you this morning, and it scares me, I am not supposed to do that——

Mr. WAXMAN. Take two aspirins and call me in the morning.

Mr. GUARINI. Lie down and it will go away.

Mr. STENHOLM. You have been very adamant in believing every State should have the freedom to provide whatever environmental rules and regulations they might want to have. Why are the States more capable of doing that on environmental issues but not capable of doing it in the area of health?

Mr. WAXMAN. My philosophy is, if the Federal Government is doing the job of setting an adequate protection for everyone in the country, either to protect them from going without health coverage or access, or protect them from environmental problems, then there is less of a need for a State involvement.

But where the Federal Government has failed, such as in the area of some of these pesticide protections—by the way, I am supposed to be chairing a hearing on that subject at this moment—then I think we are hard put to say to the States they can't go forward in that area.

So, for example, in the nutrition labeling bill, once we establish uniformity for nutrition information, then we preempted the field. But I wouldn't want to preempt when the Federal Government isn't doing the job adequately.

Mr. STENHOLM. I have some more questions, but I don't want to keep you from your hearing.

The CHAIRMAN. Mr. Dannemeyer.

Mr. DANNEMEYER. It is a pleasure to see you here this morning. Forty-nine Governors in the Union have sent a letter to Congress asking Congress to stop loading up Medicaid, because they can't afford it anymore, and I have a bill that is ready to be introduced in response to the program put up by 49 Governors of this Union that will give a little relief to the excessive level of Medicaid mandates that you helped establish over the last few years.

Would you be willing to coauthor that legislation with me and bring a little relief to these Governors of our Union? That question can be answered yes or no.

Mr. WAXMAN. If the gentleman will permit, I might consider it, but I would like to look at the following: I would like to recognize that there are real problems that need to be met, and I am sympathetic to the State burdens on these Medicaid costs.

But the biggest increase in Medicaid expenditures at the State level, which the States are suffering from, are the larger number of people that are going on Medicaid programs during this recession, and the increasing health care costs.

Those are the big problems, not the Medicaid mandates.

Mr. DANNEMEYER. Would you coauthor my bill?

Mr. WAXMAN. Probably not.

Mr. DANNEMEYER. To carry forward with—well, don't you believe that one of the principal impediments to individuals who currently

do not have health insurance around the States of the Union, this 35 million that are uninsured, is the existence of State mandates that, for all practical purposes, provides the cost of basic health coverage beyond the ability of persons of lower economic status to pay?

Mr. WAXMAN. I think that is a relatively small part of any problem of providing private insurance to people. The bigger problem is that private insurors are not spreading the risks out across the board in the population base. They are looking to exclude people who have a higher risk of costing them money, and they are more anxious to insure those least likely to be sick.

That leaves large numbers of people without any opportunity for insurance coverage. That is a big problem in small businesses, to provide——

Mr. DANNEMEYER. Let me cite, by way of contrast, under ERISA, when employers seek to be self-insured, they can bypass State mandates, is that correct?

Mr. WAXMAN. That is correct.

Mr. DANNEMEYER. Wouldn't that be a wise policy for us to consider as a means of providing a low cost, basic, no-frills health care policy that people would be able to buy?

Mr. WAXMAN. The Pepper Commission did recommend the elimination of the States' mandate——

Mr. DANNEMEYER. Do you support that?

Mr. WAXMAN. For private insurance, and I would support it in that broader context of insurance reform along with the mandate that employers pay or play to get their people covered.

Mr. DANNEMEYER. The growth in Medicaid has been absolutely explosive. For example, in the 1982—or rather, 1980, we spent a little over $14 billion. That is the Federal share. And then, as Mr. Guarini pointed out, in 1991, we are spending $51 billion. That is just a mind-boggling growth of Medicaid expenditures. And just going back to 1988 is when this true explosive growth began.

In 1988, the Federal Government spent $30.4 billion. 1989, an increase of 13.6 percent at $34.6 billion, and in 1990, an increase of 18.8 percent, $41 billion; and in 1991, an increase of 25 percent, to $51.5 billion.

We have had witnesses come before this Committee who observed—in fact, it was a representative from the National Governors' Association, that your leadership, Mr. Waxman, is responsible for bringing a national health insurance plan by the back door by loading up on Medicaid expansions. Do you agree with that statement?

Mr. WAXMAN. No, I don't believe that is an accurate statement. I think we need a national health insurance system, but I don't think it ought to be built on Medicaid. In fact, I think Medicaid ought to be replaced by a public program that is much sounder than Medicaid.

I think Medicaid is a second-class health care system. It is better than nothing for people who are low income, but it is not the ideal I would like to see for a public program for this country.

Mr. DANNEMEYER. I notice a point that Mr. Stenholm pointed out, you seem to believe the States are not capable of working up this health insurance plan for their people living in those States,

and yet looking to another field where you and I have debated over the years, namely dealing with the AIDS epidemic, in that area, you are a strong supporter of States' rights, that States should have the option of whether or not they want to enforce reportability for HIV carriers, and yet you say that instance, that is a States' right issue. I am puzzled by this paradox in your philosophy.

Mr. WAXMAN. My philosophy is not to be one way or the other. My philosophy is to try to figure out who best can do the job. I think in some cases local government is better able to deal with the unique problems they have.

In other areas such as health care, I don't like the idea that a child born in the State of Alabama is going to go without health care because he is not at the very, very bottom of the poverty level, and that a child born in the State of Michigan, who is poor but not nearly as poor, is going to get a chance at a start in life.

In those circumstances, there ought to be Federal-level decisionmaking, and in other cases, local.

The CHAIRMAN. The time of the gentleman has expired.

If you could, the remaining Members could kind of limit themselves on questions, we would appreciate it, because Mr. Waxman has other responsibilities as well. Mrs. Slaughter.

Mrs. SLAUGHTER. I certainly will do that.

Mr. Waxman, you are a hero of mine, because of the wonderful work you did in Budget last year, making it possible for poor women to have mammograms. I envy you in a way, because I always thought whoever had the opportunity in Congress to overhaul this whole system really had a wonderful chance to make a difference in this country, and the way we do health care.

I don't think we can salvage Medicare. It has been a source of irritation and aggravation to everyone, provider and recipient alike. I watched the paperwork alone nearly madden my father, who had never owed anybody anything in his life, and because Medicare was so slow in paying, the hospital would threaten to dun his house.

In the State of New York, Medicare will pay the cost of acute care, we have cost containment on Medicaid by backing people up in hospitals. Up to 300 patients who should be in nursing homes are kept in the hospitals.

Mammograms, again, we have covered women over 65, we have capped mammograms for poor women at 55, a preventive measure, while we are willing to pay unlimited cost for treatment or surgery, we are not willing to pay the amount of money for women to even get the screening procedure, even though we know in this country it is a disgrace that the breast cancer incidence goes up, but over and over again, we see that sort of thing where we are simply doing it wrong.

And my recommendation would be not to try—we are going to do something for national health, not to try to save this system. I don't think it is worth it, and to really start over and to try to cut out the duplication. No question that too many Americans are overtreated and too many are undertreated.

And we need to level that. But it really is—I think it has a major overhaul, cutting out duplication and cutting out that insane paperwork. I wish you well in that regard.

The CHAIRMAN. Mr. Shays.

Mr. SHAYS. Thank you, Mr. Chairman.

The Committee on Government Operations has been holding hearings on the work done by GAO, and I just wonder if you could respond based on your comment that we shouldn't scrap the existing system.

GAO, it seems to me, is saying you keep the existing system as it relates to the providers of health, but you have a single payor and you scrap the insurance companies and the extraordinary variety of programs.

So, it seems to me we are keeping the system, we are just deciding to have a single payor. And from that, their explanation is that you could almost cover those who don't have coverage right now. I just wonder if you could comment on that.

Mr. WAXMAN. I am skeptical that statement, that having a single payor would produce such dramatic savings that we can then not have to find any more money. But let's say that is the case. A single payor doesn't have to be the Federal Government as a single payor. The single payor can be the result of multiple payors of health care coordinated in some way, or even focused into what will be then a single payor for everybody else.

So, there are ways to deal with that without saying we are going to drop all the coverage that people get to do their jobs and have the coverage only through the Federal Government in order to bring about these efficiencies.

If these efficiencies are there, and many of them are, I just don't think to the extent GAO outlines them, we can try to bring about those efficiencies without scrapping the existing health care system and moving to a federally run program.

Mr. SHAYS. Mr. Chairman, I am done. Thank you.

The CHAIRMAN. We have less than 5 minutes left to the vote. Mr. Waxman, thank you very much for coming. I appreciate your testimony. We will reconvene about 10:20 with Mr. Stark, and then at 10:30 with Mr. Mitchell. Mr. Stark will present a statement, and we will hear from Senator Mitchell at 10:30. That is the schedule.

AFTER RECESS

The CHAIRMAN. The Budget Committee is now continuing hearings with regard to the health care issue. We welcome the Majority Leader of the United States Senate, George Mitchell, to the Budget Committee.

Senator Mitchell, what we are basically doing with the Committee is a number of oversight hearings to try to begin to lay the foundation for the budget for 1993 and also the rest of the 1990's. Obviously, health care is a principal element of that budget. We are anxious to hear the views of everyone who has offered an option, so we can take it into consideration.

Obviously, because of your position and the bill you introduced, we are most anxious to hear your views, as well. We welcome you

here. Thank you for taking the time; we know you are very busy. We will try to limit the time we have with you.

You may proceed with your statement; it will be made part of the record.

STATEMENT OF HON. GEORGE J. MITCHELL, A U.S. SENATOR FROM THE STATE OF MAINE, AND SENATE MAJORITY LEADER

Senator MITCHELL. Thank you very much, Mr. Chairman, for inviting me to testify at this hearing. I appreciate the opportunity you and other Members of the Committee afford for discussion of the issue and the legislation which I just introduced in the Senate.

The quality of health care in the United States is the best in the world for those who can afford it and to whom it is available. Unfortunately, for a large and growing number of Americans, quality health care is not available because of high cost and the lack of health insurance.

The legislation I have just introduced is the culmination of nearly 2 years of work by Members of the Senate Finance and Labor Committees and reflects input from a wide range of knowledgeable persons, including health care providers, insurers, consumers, the States, and many others.

The proposal is the first of a two-part strategy to address the major gaps in health coverage for all Americans. The second part, coverage for long-term care, will complete our efforts to assure affordable, quality care for all. I am committed to enactment of a long-term care program and intend to introduce legislation to accomplish that goal in the near future.

Access to affordable, quality health care should be a right for all Americans, not merely a luxury for those who happen to have the money to buy health insurance. As many as 37 million Americans have no health care coverage, according to some estimates. Millions more have insurance coverage which is not adequate to protect them from the costs of serious illness.

Furthermore, the rising cost of health insurance threatens coverage for many who are currently covered. Nearly 1 million Americans lose their health insurance coverage each year, often because their employers are required to drop coverage because of rising costs.

The problem of the uninsured is not principally a problem of the poor, contrary to widespread and common belief; 70 percent of the uninsured are above the poverty level. Nor is the lack of health insurance coverage principally a problem of the unemployed. Two-thirds of the uninsured are working persons or their dependents, whose jobs do not provide what was once considered a routine benefit of employment, health insurance.

One-third of the uninsured are children. One out of every four children in the United States is not covered by health insurance.

The underlying problem in our Nation's health care system is the rapidly rising costs, which is eroding the foundation of the system for all Americans regardless of income. We must find a way to bring health care costs under control, or we risk adding millions more to the numbers of the uninsured, and then face a true national crisis of health care.

In 1990, overall in this country, there was spent $671 billion on health care, approximately 12.2 percent of the gross national product, up from $604 billion and 11.6 percent in 1989. The projections for next year are for a continuing increase.

Yet, in spite of the tremendous amount of money spent on health care and our Nation's truly spectacular advances in medical technology and treatment, our health care outcomes compare poorly with many other industrialized nations.

In infant mortality rates, maternal mortality rates, mortality rates for low-risk and high-risk surgery, life expectancy, in each of these categories, we trail other nations, and in some we are way behind.

I believe we must build upon the existing public-private mix in our health care system, which asks employers to provide access to health care for their employees and their dependents.

The legislation I introduced will require all employers to either provide private health insurance to their employees or contribute to a public program which will provide that coverage. The program will replace the existing Medicaid program for all services except long-term care. All persons not eligible for employer-based health insurance will be eligible to receive health insurance coverage through the new program, which we call Ameri-Care.

It is a dramatic new public program. There will be Federal standards for eligibility, benefits, and reimbursement. The program will be administered by the States.

The legislation recognizes the special problems and needs of small businesses. It provides a lengthy phasein period and financial assistance to small business in the form of tax credits, to encourage them to participate and to help them to adjust to the requirements of the legislation.

If this legislation is to accomplish our goal of providing quality, affordable health care for all Americans, it must have as a central feature meaningful cost-containment. The cost-containment provisions included in the bill will, we believe, result in significant reductions in the rate of increases which have occurred and are occurring in the system.

The establishment of a National Health Care Expenditure Board and State consortia are the linchpin of the cost-containment provisions, which are estimated by one study will save nearly $80 billion over the first 5 years in which the bill is in operation.

Let me repeat and emphasize that we believe that enactment of this legislation will save nearly $80 billion in health care costs over a 5-year period.

Mr. Chairman, some argue that the United States should adopt a national Government system on the Canadian model of national health insurance. Others argue that tax incentives to businesses, with no requirement to provide coverage, is the best alternative. This bill represents a middle ground between those two views. It is based upon our own—our American customs, traditions, and practices.

I have been pleased with the generally positive response the legislation has received from a wide range of groups, including the American Medical Association, the American Hospital Association, the Washington Business Group on Health, and the National Asso-

ciation of Manufacturers. While each of these and other organizations has expressed reservations about some aspects of the bill, all have expressed their general support and enthusiasm for the effort.

Providers, insurers, and consumers alike recognize the need for action now, if we are to provide meaningful, affordable health care for those Americans without health insurance, and to protect the access to insurance for millions who are in jeopardy of losing their existing employer-based health insurance, because of rising costs.

Mr. Chairman, I want to recognize and thank for their efforts Senators Kennedy, Riegle, Rockefeller, and Pryor, each of whom brought a unique perspective and commitment to the drafting of this legislation.

I look forward to working with my colleagues in the Senate and with you and others here in the House, Mr. Chairman, to enact meaningful health care reform.

I want to repeat something I said on the day we introduced this bill, because I think it has special relevance in a legislative committee. We do not present this as the perfect answer to the problem, as the only answer to the problem, even, necessarily, as the best answer to the problem. We present it as one answer, which we believe to be a serious, thoughtful effort to deal with the problem.

We invite constructive criticism. We invite alternative proposals. We are attempting to bring into focus the debate on the issue and to coalesce the many divergent interests who share in common a desire to make the right of adequate health care for all Americans a reality.

Mr. Chairman, thank you for your invitation and for your attention. I will be pleased to try to respond to any questions. I have with me Christine Williams of my staff, who will take the tough ones; I will take the others.

The CHAIRMAN. Thank you for your testimony and taking the time to present your program to us. Let me just ask a couple of very quick questions.

First of all, again with regard to the cost issue, I don't know if you have had CBO estimate the net additional costs to the Federal Government, but do you know that number? I think Henry Waxman, who testified earlier on his proposal, which is somewhat similar—there are differences, obviously—estimated his was about $24 billion. I don't know if you have a cost estimate.

Senator MITCHELL. In the first year, we received an estimate of approximately $6 billion, but that is not fully phased in. We are awaiting the results of an estimate from the CBO of the first year, fully phased in.

The only comparison we have is that a Pepper Commission proposal, comparable but not identical, was estimated at about $14 billion a year. We think that, given the differences, the estimate might be a little higher for this one when fully phased in.

I believe it will be less than the figure suggested by Representative Waxman for the other legislation.

The CHAIRMAN. Finally, again I guess the question is from your perspective as Leader in the Senate, do you expect that this is going to be something that will have to be debated as part of the Presidential campaign, before Congress, in fact, can proceed with

any major changes in the health care program? Do you expect that it is something we could proceed with in this session of Congress?

Senator MITCHELL. Mr. Chairman, I don't believe that meeting the needs of American families in health care should be related to election dates. There are ongoing tragedies throughout this country that are unrelated to elections and election dates. I hope that we can have a constructive debate.

I recognize there are many who disagree with this approach and have alternative discussions. We invite those. We specifically invited the Administration to make a proposal.

I want to tell you about a visit I had 2 weeks ago to Fargo, ND. I had attended health care forums around the country. While in that city, I was invited to visit a local children's hospital, St. Luke's Children's Hospital in Fargo, ND, a regional children's hospital, a fine facility serving a large geographic section of the upper Midwest.

The attending physician took me first to meet a young family, farm family, which farmed near Fargo. As with many farm families, the income is seasonal and generally down in the winter. They had a particularly difficult time last year. So, to save money, to get by the winter, they decided to suspend payments on their health insurance coverage for a few months.

As you might expect from my telling the story and, tragically, just a short time before they were to resume paying on their health insurance, their 14-year-old son was seriously injured in an automobile accident. He has what doctors now believe to be permanent brain damage.

His hospital bill is already in the tens of thousands, will soon reach the hundreds of thousands, and probably reach the millions. They were without health insurance coverage. Of course, this is totally beyond their capacity to deal with.

In the very next room, we met a young boy of 2½ years of age and his mother. The boy has never spent a moment of his life outside the hospital; every living moment in 2½ years he spends—has been spent inside the hospital at a cost of about $1,500 a day—completely beyond the capacity of the family to deal with it.

Mr. Chairman, if these were isolated cases, we would feel the need for compassion for the families, but not feel the need to legislate nationally, based on one or two instances. But what every Member of this Committee knows, every person in this room knows, these are not isolated instances. These instances, these examples occur in every State, in virtually every community in the country.

It seems to me that the agenda of the Congress must be the agenda of the American family. American families are deeply concerned about health care costs, I emphasize, not only those who are without health insurance; it is a source of enormous anxiety and fear among American families, virtually all, regardless of income, except for a very small number of Americans who can live secure in this circumstance. So I hope we can act as soon as possible.

Mr. Chairman, I would like to comment further on the cost—the question you addressed. The question you ask is appropriate. It is always the first question. But I hope we will also focus on the aggregate savings. We are spending money as a society far more than

is necessary, in my judgment, and far more than we can afford, and we simply cannot continue this upward spiral.

So while focusing on the public portion of the program, the costs of the public portion of the program are appropriate and especially relevant to legislative bodies, we also have to look at the aggregate savings. We have at least one study from a respected analyst which suggests that this will save, overall, approximately $80 billion over 5 years.

The CHAIRMAN. Thank you. Mr. Gradison.

Mr. GRADISON. Mr. Chairman, I want to thank the distinguished Leader for being with us and to congratulate him and his Democratic colleagues for developing this comprehensive plan. One can, as I do, disagree with the conclusions and still have enormous respect, as I do, for what is involved in putting together such a plan.

I don't think it is accidental it took several years to develop this plan. It is not an easy thing to do. Those of us who have been involved in trying to do it on our own or in other contexts—I was the Vice Chairman of the Pepper Commission—know the difficulty there is.

One of the things hampering us from action has been a sense that everybody's second choice is to do nothing. The tone with which the Leader has presented this plan is one I deeply respect, which is: This is our best shot. You believe in it, of course, but there may be room for conversation and change and compromise.

I did have one very narrow question I wanted to make sure I understand.

The emphasis in talking about the plan is on the employer pay, that is, the employer mandate. Am I correct, in effect, that there is a mandate on the individual, as well, up to 20 percent, so that in a sense if that farmer had a way to get somebody to pay the 80 percent, he would still have been required to come up with the 20 percent, even in the bad months?

Senator MITCHELL. Yes, sir.

Mr. GRADISON. Thank you very much.

Senator MITCHELL. Let me say, if I might comment in response to that, it is literally true, and we know especially who are involved in legislation, that the solution to every human problem contains within it the seeds of a new problem. That is the dynamics of change within human societies.

Many years ago, not by any grand plan or design to meet what was, in fact, an unmet need in our society, we began a process which has resulted in the separation of the payment for health care from the receipt of health care services. That has met, to some degree, what was an unmet need; but it has, at the same time, created overutilization and a problem of attitude with respect to the quantity of health care services.

Consider this fact: In ours and every developed society, there has grown, in recent years, a very large industry based upon the simple premise that a person who can defer the payment for a good or service will purchase more of those goods or services. I confidently predict that almost everyone in this room has one or more credit cards in their pocket. It is a large and very successful industry, which operates on that simple premise: If we can defer payment, we will buy more of things. In fact, we do.

Imagine, then, the effect on attitude if another person believes that they do not have to pay at all. If their attitude is, I am not paying anything for this, we readily, of course, are prepared to purchase more.

To some extent—and it ought not to be exaggerated, but to some extent, that is a factor in overutilization and the volume of services provided today.

Now, the CBO tells us that it will require enormous corrective effort to produce a very small benefit. That may be so. But I think we have to begin to change attitudes and convince every American that they are paying, because, in fact, they are. I believe that the principle of participation to the extent possible, given levels of income, must be implemented.

We do provide—I should say that below the poverty level, the cost of the insurance is fully subsidized. Beyond that, we provide a sliding scale up to double the level of poverty for health insurance coverage.

On the question of attitude toward this approach, I can only say that having gone through this process, there are many close and difficult judgments to make, over which we spent long hours deliberating. As we know in our daily work, if you have to make a close call, you cannot confidently and certainly say that someone who disagrees is wrong; but what you can say is, these are the facts, this is the evidence, this is the side on which I came down, let us hear from those who hold a contrary view.

The CHAIRMAN. Thank you, Mr. Leader.

We know you have constraints on time. Does any other Member have a question for Senator Mitchell? Mr. Santorum.

Mr. SANTORUM. I would like to follow up.

I go to a lot of town meetings. They say, when are you going to do something about health care? I think the Chairman hit on a good point. I don't hear any consensus of what is happening with health care in the Congress.

I know we should not consider problems based on election pressures, but I think the Chairman points up a very appropriate thing, which is, we need a national debate on this.

I appreciate what you are doing here. I think it is appropriate that you do that. But my sense is that we are not going to see any health care reform in this Congress; we are going to need some sort of national debate.

I would like your comment more directly as to whether you think that is the case or whether you think it is going to happen this year.

Senator MITCHELL. I cannot say this year. I am going to try as hard as I can to make something happen this Congress.

I agree, there ought to be a national debate. That is one of the principal reasons why we advanced this proposal, to attempt to create a specific context within which a debate can occur.

I believe your comment about the lack of consensus for a solution is exactly right. There is a widespread consensus that a problem exists. There is a deep and growing concern about the effect of the problem. But there is not a consensus on a solution. That is really what we need to do. That is the effort here.

It may be that it will take the decade it took Medicare or the 9 years it took to get the Clean Air bill passed. That happens in our society. I cannot, with any certainty, predict the point at which public attitudes will coalesce and compel the Congress to act.

But I do believe that it is possible that it can be done, and I hope will done in this Congress. I am going to do all I can to see that it does.

Mr. SANTORUM. I don't mean to take up all your time. What do you think will cause it? Everyone says we have a crisis now. There is recognition in the public there is a crisis now.

What one thing or things will move as to action?

Senator MITCHELL. I don't believe in the process by which democracies act, that there are frequently specific single traumatic events which cause legislation. That does happen from time to time.

I think on something like this it gives just another growth in public awareness, public concern, and the number of people who are directly affected by the problem.

You see, the significance of the two children in Fargo, ND, is that every audience with whom I have spoken—and there have been many in which I have told that story—15, 20, 30 people come up and say afterward, my neighbor had a similar situation, someone down the street, a relative, a family member.

I think as the problem becomes more pervasive throughout our society, the public demand for it arises. I cannot say to you when the line will be crossed at which action will become inevitable. I hope it is in this Congress. I intend to do all I appropriately can to make that occur. I understand the contrary point of view which suggests it may take time beyond that.

I hope that that is not the case. We are just going to press forward as best we can.

Mr. SANTORUM. Thank you for the time, Mr. Chairman.

The CHAIRMAN. Mr. McCrery.

Mr. MCCRERY. Mr. Leader, forgive me, I was not here for your remarks in chief.

The remarks that you made just prior to Mr. Santorum's question about overutilization of the system, due to third party payers, so forth, sounds a lot like the Heritage Foundation study. Are you familiar with that study? Is that what you are talking about basically?

Senator MITCHELL. No. I think they were quoting me.

Mr. MCCRERY. Is that right? I wasn't aware of that, that you came up with the idea first.

Senator MITCHELL. Personally, I am not familiar with that particular study. I read many of their reports because I find them to be very informative and instructive, frankly, although I do not agree with many of the conclusions. I think they are generally well-researched and well-written reports.

Mr. MCCRERY. I happen to agree with that facet of their study and with the remarks that you made. I am wondering how your plan addresses that. Can you just sum it up?

Senator MITCHELL. It provides for copayments and deductibles. Participation is in the payment for the health insurance coverage for all persons whose incomes are above the poverty level.

The cost of the health insurance for persons not covered through employment is fully paid under the public program for persons whose incomes are below the poverty line. Those from the poverty line to double poverty, there is a sliding scale in which beneficiaries must participate. Above double, they are fully responsible.

Mr. McCrery. What is your basic plan? Is it front-loaded? Does it have first dollar costs involved? How do you provide for the basic plan?

Senator Mitchell. Well, we provide a specified basic package of benefits that will be provided. I will just tick them off. They are very brief: hospital services, physician services, diagnostic and screening tests, limited mental health benefits, prenatal and well-baby care and some health benefits including mammograms, pap smears and well child care.

Cost-sharing will be required and I will just give briefly as follows: Deductibles of $250 per single person, $500 for family; 50 percent copay for outpatient mental health benefits; and wage-related cost-sharing may be used as an alternative. So there are specific deductibles, copayment provisions in an effort to create an awareness that everyone participates in the costs which is, unfortunately, not an attitude that is widespread today.

Mr. McCrery. Thank you for that explanation.

I think you are on the right track. I think we may need to go further.

The Chairman. Mr. Shays.

Mr. Shays. You are an expert witness. Frankly, you know so much about this issue. In addition, you have the added advantage that you are a tremendous power in this institution. I would love to be able to ask you a few questions and also to say Norwalk, CT, appreciated your visit a few weeks ago.

Senator Mitchell. Thank you. We had a nice time. I appreciated the opportunity to visit with you there.

Mr. Shays. It seems to me we are going to have universal coverage in part because people used to say we couldn't afford universal coverage. Now, we are saying we cannot afford not to have it.

You have the $30 million who have no insurance; a like number underinsured. You have individuals that have no insurance and trying to get it at a cost they can afford. Small businessmen who have traditionally been against those are saying if they have to provide it to their employees, they can't afford it.

What is interesting to me are the corporate presidents coming to me and saying the costs of their product overseas are just too high because of the health care element, cost element. I see us moving in that direction.

Now, my concern is that this is the one area in this country that when I, as a Congressman, ask people to come in, they don't have an answer. They have suggestions. Nobody has a great answer they are confident in.

So my concern is that if we move in that direction, in the process we are going to screw it up. I guess the process has to be that we debate it and come to a conclusion. It seems to me as I have argued it, we have to decide the question, whether we scrap the system and go to a Canadian system in the sense we scrap the payment side of it but keep what we have—the doctors, the hospitals—all

the same. That is one issue; or whether we build on the present system, and have many insurance companies involved.

It seems to me one way you make savings is to have a single payer. But the downside—is that a service that is free is overutilized. So what I would like about what you are doing is the copayment, even if it is a small copayment. That brings in the whole element of lots of paperwork, so we do not make the savings.

So I guess the question is, you mentioned you looked at all these tradeoffs. In your judgment, was the copayment aspect important and a bigger benefit in terms of cost savings than simply not having the paperwork, and if you went to a hospital, you went to a doctor, you were covered, plain and simple; you gave him the card, you walked out?

Senator MITCHELL. No, it is not as significant a factor as the other one. But I think it is an important factor in changing attitudes in saving costs over the long run.

I believe that the most significant cost control mechanisms in this legislation is the establishment of a national health care expenditure board which would set national goals both aggregate and in sectors and State-by-State and then the legal authority for States to establish insurance purchasing consortia which would at a minimum be required to enroll insurance companies with a small share in the market to participate in a single payer system for the purpose of reducing administrative costs.

The States would have additional optional authority, but that is the way in which I believe we can save money.

On the earlier question—which is really the fundamental question that our society faces—should we move to a national system along the Canadian or other type?

First, of course, it has been noted often we are only one of two industrialized nations without a Government national health insurance system. But when you get beyond the labels, you find that although the other countries all have in common a Government system, they are not all the same.

The Canadian system is very different from the British. Both are very different from the West German system. What you find is that in each society, the system has developed out of the customs and practices and traditions of that particular society.

In our society, insurance has been the principal means of assuring adequate health care access and the principal means of providing insurance has been through employment.

I believe that the political feasibility of now at this point in history going to a fully national system such as the Canadian system is so relatively low that I would prefer to concentrate my efforts and energies on that, but to seek something which I believe to be consistent with our practices and yet attainable and meaningful.

I want to say to you that that is not a popular view in my State. I have been fortunate to have been elected twice in my State by substantial margins, but there are two occasions on which I am always booed by Maine audiences. One is when I speak at high schools and state my position in favor of longer school days and years; and the second is at every single town meeting, where people get up and demand that we adopt a Canadian-style system

which I say I don't favor that. The national figure is 70 percent of Americans would favor it.

In my State, perhaps because of our proximity to Canada and frequent exchange of citizens back and forth and thereby greater familiarity with this system, it is much higher than that.

But I don't think it is feasible. I don't think we could pass it. I don't think the President would sign it. Therefore, one must decide, as we all do, we only have a certain amount of energy, effort within us, how are we going to concentrate?

I think this is the way to go now. I say this, and I said this to every provider with whom I have talked, and I have talked to hundreds of them. Those who have a stake in the current American system must participate in reforming it. I believe if we do not make this kind of, and I emphasize this kind of, not this particular kind of bill, change of this order and magnitude, then the national tide in favor of a Canadian or other style system will become overwhelming. Not this year, not next year, but I say to you within the lifetime and Congressional careers of most of the people in this room. Probably by the end of this century.

The only thing holding back the American people now is 70 percent want a national system, 80 percent don't want to pay any taxes to finance it. But when they figure out that premiums are taxes and they are functionally interchangeable and that they can actually reduce their aggregate cost by participating in a national system, the 70 figure will go to 97 percent.

So I think this is the best course to take now. I recognize there are valid, indeed some compelling reasons for the two alternatives, one going all the way to a nationalized Canadian system, the other to do nothing. I think the do nothing one is the least compelling one of all. I think we have to do at least this much.

Mr. SHAYS. If we are looking at a single payer, the low end of the savings was $34 million. The high end of the savings was $67 million. That is really what GAO said.

I am just wondering if you are comfortable with that, if you are comfortable with those statistics, if there would be that savings?

I guess the point is the explanation that GAO made when they came before Government Operations Committee was you can basically fund all the uninsured by the savings you would make by the single payer.

Senator MITCHELL. Yes. We provide single payer at the State level. Now, I don't think that the savings in the aggregate would be as great as a national system and the GAO, I assume you are referring to their study, the—what we can learn from the Canadian system, I think, was the subject of the study.

I think it is a valid study. I think we could achieve significant savings in that. For example, the question is whether as a policy matter that is the manner in which we want to achieve those savings. There are many things we could do here to save money we reject on policy grounds. I think that that may be the case there as well.

I think there is much to be said for the Canadian system. I want to say that. It certainly suits the Canadians well. No Canadian political party or elected official would advocate changing their

system our way. But I think we are best to build on what we have developed in this country.

If I may make one other point that is relevant to what you said before I have leave, what is really involved here, for example, is a conflict in objectives. You have an existing system in which too much money is being spent. On the one hand, you want to expand the existing system. You want to insure people who are not insured to provide services not now being provided. By itself, the inevitable result of that action will be to increase the costs. And you will not get people whom you have to have participate, particularly business, through whom the insurance is to be provided, if that is all you are going to offer. So you have to have effective cost containment. They must be persuaded that costs will not continue the current rate of increase, let alone at an even faster pace.

On the other hand, to do that, you are dealing with all of the providers, each of whom wants cost containment in the classic American way so long as it does not impinge on them directly.

That is perfectly—that is not American. That is human nature. Our entire economic system is based on the premise that people act out of self-interest so we should expect nothing less of anyone in this industry.

What we have to do as legislators to figure out a middle ground that reconciles those two substantively and politically. How do we come up with legislation that does the job and that can be enacted?

I think that that is the challenge we have. It is an immense challenge. I am convinced we can meet it.

I was involved, as Chairman of the Senate Health Subcommittee, with the ranking Member here, as he will recall, in the 1987 actions with respect to Medicare and Medicaid. There is a lot of knowledge in this Congress. There is a lot of—there is a great desire to get something done.

One of the reasons for doing what I have done, respect to so many hundreds of hours at this, is to try to create a method by which we could focus the debate, generate discussion, get conflicting ideas; and out of it, hopefully, will emerge meaningful action to help deal with the problems that we are all concerned about.

The CHAIRMAN. Mr. Leader, thank you very much for taking the time again. Obviously, you are a leader, not only in terms of your capacity in the Senate, but also one that is perhaps the leader of compassion when it comes to this issue.

But more importantly, your commitment to getting it done. I think that that is the key here. We can all talk about various theories. We all know those theories don't mean much to the person in the hospital unless, in fact, you get it done and obviously your proposal is a real stepping stone in that direction. We thank you for your leadership.

Senator MITCHELL. Thank you, Mr. Chairman.

The CHAIRMAN. May I ask for you to provide a short summary of your bill? We would appreciate that. Members have asked for that.

Senator MITCHELL. We have a short one, a slightly longer one, and a real long one. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Leader.

The CHAIRMAN. For the Members of the Committee and other witnesses, we have a vote on the foreign aid bill. It could be followed by a series of votes with regard to amendments.

I think the best way to leave this is that we will return after those two 5-minute votes. Mrs. Johnson, you will be the first witness at that point.

Let me also, for purposes of the record, submit the testimony of Mr. Stark and Mr. Russo who may appear later if they have time.

At the same time, I would like to try to make their testimony part of the record. We will convene after these two 5-minute votes.

[The prepared statements of Mr. Stark and Mr. Russo may be found at end of hearing.]

AFTER RECESS

The CHAIRMAN. The Committee on Budget is again in session for consideration of health care costs and access with respect to future budgets.

For the panelists, we are going to proceed with the panelists and the others I guess in as expedited a fashion as possible.

I apologize for the delays, but it is something you always run into in terms of giving Members their ability to ask each of the witnesses the questions that they want to ask. So we will try to move ahead as expeditiously as we can. I apologize in particular to Nancy Johnson. We are in the middle of votes, too, so it is a combination of two things.

But we do welcome you. Your statement will be made part of the record. You can summarize it, or read it as you wish.

STATEMENT OF HON. NANCY L. JOHNSON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CONNECTICUT

Mrs. JOHNSON. Thank you, Mr. Chairman. I do appreciate the opportunity to appear before you and your colleagues on the Budget Committee today to discuss the trilogy of access, cost, and quality in health care.

It is important as we enter into this discussion to remember to be proud that the United States offers the highest quality medical care in the world, the best technology and pharmacology, the most sophisticated medical providers. But we must be ashamed of the system's failure to serve millions of working and nonworking poor, and appalled at the spiraling costs that increasingly threaten those with, as well as those without, health insurance.

28 million workers and their dependents are uninsured and ineligible for publicly funded care. Another 6 million individuals and their dependents lack both work and eligibility for publicly funded care. This means low-income pregnant women go without prenatal care and millions of children don't receive basic immunizations, to give just two examples of the severity of the problem.

But it is not the insured that are driving the public's concern, interestingly enough. It is rising health care costs and the threat they pose to the access that those who have it enjoy.

If you remember, those same polls reveal that there is no understanding of the dimensions of the challenge we face, nor of the formidable tradeoffs inherent in achieving an affordable national

health policy that guarantees universal access and controls health care costs.

I think that is very important, because as Members say, their constituents are saying, we want the Canadian system, but what they are really saying is, "We want everyone to have access and we don't want to fear the loss of our own health insurance." The level of knowledge of what it means to be in the Canadian system is very, very low, and particularly the sensitivity of the tradeoffs is hardly there at all.

The cost crisis in our health care system did not happen overnight. Our best efforts to stem health care cost increases over the past decade through Government price fixing in Medicare, Medicaid, and the VA system have met with failure, albeit periodically masked as short-term success. And I think that is important.

It appears to us we have succeeded in controlling costs in the health care system because we have defined as ineligible a whole range of veterans. In fact, we have done certain things that are heading us down the path that Medicaid has traveled and that has resulted in markedly reduced access and quality.

Health care costs continue to rise in spite of all these efforts at substantially higher rates than the rate of inflation. U.S. health care costs are now over 12 percent of our gross national product. We are talking about affecting 20 percent of the economic activity in America. There is hardly anything we do on the Ways and Means Committee that at one stroke of the pen affects 20 percent of the economic activity in our Nation.

It is imperative that we correct the access quality and cost problems. But we must not destroy the remarkable strengths of our system as we correct its weaknesses.

Radical reform is not imminent, in my opinion. It is also not appropriate. And this goes to the earlier discussion of a national debate. There are many technical, structural and ideological issues that have to be addressed. Making responsible and constructive changes affecting up to one-fifth of our Nation's economy takes time.

Being an incrementalist makes me a radical, because I fervently believe that incrementalism means action now. It means differentiating between those things we can do today that will make a real difference in people's lives in terms of access and cost control, versus those things that we can't do today and that rightfully ought to be part of that national debate that will take a number of years to gel, to make a few more systemic changes.

It is my opinion that we cannot even define what the systemic changes ought to be or what is the best form, or means of addressing them, unless we take some very simple but formidable actions today.

My program for reform today is laid out in H.R. 1565, my health care reform bill, also known as HEART. It would reform the small firm health insurance market, thereby making coverage available to nearly 20 million workers and dependents without health insurance.

It is important to remember that of the people who are uninsured, one third make over 200 percent of poverty income. Affordable insurance could reach them as well as a number of others.

Costly State mandates would be overridden through the provisions of my bill in order to make an inexpensive plan available to small business and all variants of the basic plan would be free of State mandates.

Mine is the only proposal out there that allows competition among basic plans without the control of State mandates just for the small group market. As long as they do four or five things, in order to be free of State mandates, we would set certain Federal standards.

We would not allow exclusion for preexisting conditions after initial qualification.

We would limit rate increases, guarantee renewal except for nonpayment of premiums, and would force conformance to public disclosure and certification requirements.

We could write significant legislation reforming the small firm market this year.

My proposal is out there in detail. Senator Durenberger's proposal is out there in detail. Senator Mitchell's proposal is out there. It is doable. It can reach at least a third of the uninsured, make a material difference, and if you remember it will help us when we get to that point in Senator Mitchell's bill and other proposals, when we want to define what is that basic health care that we want to make available to everyone.

This competition of mandates in the basic health care proposal will give us guidance. We could do this now, it could be in place in a year. We would materially alter the access issue by doing that.

The second thing we could do, and the Senator did not address this except obliquely, and I feel it is very important and we could do it right now, we could reform our own tax code to do two very important things.

First of all, to allow the self-employed the same tax benefits we allow employers by giving them 100 percent deductibility.

Second, we ought to change our current tax laws so that, in order to get the very generous tax benefits that we provide to employers, you would have to encourage smart buying. We should only be providing tax incentives for plans that have a managed care component or copay structure or meet certain other criteria spelled out in my bill. That way, you drive the whole private sector toward thinking managed care, toward thinking smart purchasing. And you materially alter the current incentives in the system. That is probably the most profoundly important thing that we could do.

But between reforming the small business market, altering our own tax code in modest ways to encourage managed care, which we have seen has a dramatic impact on costs, and to address the problem of the self-employed, we could really address both cost and access.

Third, my bill addresses the need for quality by beginning what Bill Gradison was so instrumental in doing on the Ways and Means Committee in a general sense through fostering guidelines and outcomes research.

My bill would do that in a more specific sense in the hospital setting through initiating Quality 2000. It will take a while to get on

line, but Quality 2000 is a well-thought-out plan to monitor hospitals so that it does reduce the inappropriate use of our resources.

Fourth, for those individuals and families even under the HEART plans, tax reforms and small business insurance reforms, who could not obtain affordable health care coverage, it would expand health care clinics to ensure neighborhood access to the low-income uninsured.

It is a dirty little secret that even after the recent series of eligibility changes in Medicaid, 61 percent of families below the poverty level remain uninsured and ineligible for Medicaid. These centers would bring out patient care and quality physicians directly to those in need. They would provide the linchpin for a network that could offer drug treatment services and access to such important preventive health services as WIC.

Since they offer care to all through their sliding scale fee, and they do, I just visited one Friday afternoon in which 50 percent of its clients are self-pay, they can assure health access to everyone in the near future. All those that perhaps the reform of the small business market couldn't reach, the expanded community health center program could reach.

A setaside needs to be worked out to implement what is referred to as the EACH's and PEACH's program to recreate the family medical care institutions that have been eroded by today's problems in rural America.

One additional but important reform is that HEART would shield community health centers from exorbitant liability insurance premiums. One-fifth of the money in that program is going to pay liability premiums and they only had $2 million in claims last year. If we adopt this tort reform for those clinics, then we will save 10 percent of their budget and add an additional 1 million individuals to their service community without expending a single additional dollar.

This brings me lastly to H.R. 1004, ensuring access through medical liability reform. By changing the laws covering medical malpractice, we can increase access to health care, and this is particularly true in terms of poor neighborhoods and rural areas where obstetrical care has practically vanished; it is scarce because there is such a high incidence of complicated pregnancies. The D.C. premiums are so much higher than those just across the river that D.C. is losing what obstetrical care it has to other jurisdictions.

I think this is something we have to focus on. It is not just a question of cost, although that is important. It is a question of access. It is a question of access to justice because our current malpractice system is too expensive for the majority of victims, and it is a question of quality. Because if the small malpractice cases don't get into the system, you can't identify poor providers early in their career and you have to wait until they make more serious mistakes before you can get them out of the system.

So malpractice reform is an issue of quality, it is an issue of justice, it is also an issue of cost in terms of premiums and defensive medical cost.

My malpractice bill is both tort reform and process reform, and I won't go into details of it further. They are all laid out in my written testimony.

There are no easy solutions to our health care crisis, but we can and must assure that the 34 million Americans currently without health insurance will have access to quality care. The cost of care must be affordable to the individual, the employer, the taxpayer. And the quality of care must remain high. This means making sure that the care is appropriate to the problem, that the right numbers and types of providers and technologies are available, and that those providers are qualified to do the job.

Lastly, the system must maintain the quality we are world renowned for and provide choices, for that is what I believe America is all about. I believe H.R. 1565 and H.R. 1004 are good steps toward achieving all these goals.

In conclusion, since my real message to you is that there are actions that we could take now, at the same time the national debate ought to go ahead and guide us for steps in the future.

Let me just remind you that between Senator Mitchell's bill and my bill there are four very important conformities. First of all, we both propose reforming the small business market. I would guess we do it in the same way except that I create this basic plan that I call Medaccess as part of the small business reform.

I believe creating Medaccess will give us guidance to do what he wants to do later, which is Ameri-Care. There are some other approaches to the problem that Ameri-Care solves in his bill, but certainly reform of the small group market with a basic plan is something we could do right now, and there is a lot of agreement behind that.

Regarding expansion of the community health clinics, he has basically the same proposal. We are in agreement on that. And that is extremely important in terms of expanding access for low-income people, but also for a lot of the working uninsured.

He recognizes the problem of malpractice reform. He doesn't actually adopt the reform proposal. He proposes a grant program to develop alternatives. But there is a lot of good thinking and good work that has been done there, and if we did nothing else but mandate some alternatives in terms of process, that would be a big step forward.

And last, he does provide the self-employed with 100 percent tax deductibility for health insurance premiums. And if we could implement that with some adjustments in how we tax benefit, employer-provided plans, that would be a powerful initiative.

Areas in which the Senator and others in both bodies disagree will take somewhat greater time to address. Whether we should mandate this on small employers, we ought to decide that.

When we get a small plan out there and we get cost controls in place that enable us to say to this small business owner, we could tell you how much it is going to cost and we can tell you the vector of growth, so that we can assure you that if we require you to do this, this is what will happen.

I personally prefer requiring the individual to guarantee that he has coverage. He can do that through his employer or through a clinic card. And if those alternatives are actually there, I think this decision should be made down the road. Do we put the burden on the individual or the burden on the small employer to demonstrate that you are covered by insurance?

Likewise, with the issue of premium subsidies. We looked at that, and from our work in Medicare it is very hard to do this, whether it is State run or federally run. That again is another issue that would be best looked at after we have expanded the clinics and we see what their experience is with income- sensitive premiums combined with low-cost health insurance.

That section of the Senator's bill, and it is analogous to what is going on in our side in terms of exploration and discussion, can easily be looked at in 2 or 3 years, and a final conclusion drawn.

I just hope we will not wait 2 or 3 years to make some of the dramatic changes. And one of them is specifically under your Committee's jurisdiction, the expansion of the community health center program.

I have visited everyone in my State now. They are remarkable. They provide cost-effective care. They are centers. They are able to reach families in terms of abuse prevention, substance abuse prevention, child abuse prevention. They do reach into housing counseling to prevent eviction and so on and so forth.

They are an opportunity that simply awaits our attention and our development, and in my estimation, my view of public health is a nationwide system of community health centers that serve a whole group of people, not just Medicaid recipients but a whole group of people working and nonworking, many of whom are making the choice to go to that clinic because it is multifaceted and user sensitive and family caring.

Last, I would just like to say there are administrative changes that we could begin to make this year that would affect costs. Mr. Bowsher, of GAO who wrote that study and estimated the cost savings, testified last week before the Health Subcommittee in favor of increasing the administrative money that we put into Medicaid on the basis that we save $14 in health care costs for every dollar we invest in administrative oversight. He agreed we needed more administrative oversight in order to control costs in the Medicare program.

Now, when you put that testimony along with his other testimony, you have got to examine rigorously the assumptions that the GAO estimates were based on, because those assumptions assume that we can control costs the way that Canada does, and they do it by controlling the supply of physicians, which they control rigorously, the amount of technology, which they control rigorously, and the intensity of the use of that technology. The Government controls volume and intensity and supply. And so of course they can reimburse simply.

We don't control any of those things. We lost that control a long time ago. That is one of the problems. We control volume intensity through our reimbursement mechanism.

And Mr. Bowsher acknowledges this himself, there is no way that you can allow increased access to care as all of these plans will do, and not have a reimbursement system that looks at whether that care was necessary or not necessary. That kind of payor system is by definition more costly, and he acknowledged that in testimony last week before our Committee. So I would urge you to be cautious about administrative savings.

The AFL-CIO commissioned a study that showed that the costs were likely to be $34 billion, not $67 billion. So we have got a lot of work to do in that area.

We are no model of administrative efficiency when we have a Medicare system that sends out notices saying "this is not a bill" to millions of Americans, and to rely on us to make administrative reforms that will save money of that dimension is to assume something that we have not been able to prove in defense procurement reform, in Medicare administration, or in any other aspect of our work.

So I hope that you will look at those modest but very important incremental reforms that can affect access and costs that we could do this year. And in that way, contribute very materially and strongly to the national debate.

Thank you, Mr. Chairman, for your patience.

[The prepared statement of Mrs. Johnson may be found at end of hearing.]

The CHAIRMAN. Thank you very much for your contribution. We really appreciate your testimony and your taking time to present it.

Obviously, two challenges in dealing with the health care issue are the cost and the access problems. The question I have is, you allow the States to have the option of participating in the Medaccess plan under your bill. The question is, What happens to the uninsured in the States that decide not to participate?

Mrs. JOHNSON. Actually, under my bill, all States must allow Medaccess to be sold. And all providers must offer it.

If you remember, employers are obligated to educate their employees about Medaccess, what it offers and what it costs. And they are obliged as well, if their employees wish to take it, to administer it.

One of the interesting parallels between Senator Mitchell's bill and mine that I didn't mention, because it has to do with a bill that our colleague Rod Chandler introduced, is that he and I both make a provision for encouraging the small business community to merge their programs to realize administrative savings.

We know from experiments that are going on out there that if you can provide a basic health care plan without mandates, you can reduce costs. If you merge administratively, you can reduce costs sometimes by 30 percent, sometimes higher. And if we relieve the premiums on those plans as we do for the self-insured, then you can further reduce costs.

So there are dramatic things we can do that would drive costs down by about 50 percent in the small group market and thereby really expand access for working people.

It is my belief that any small businessman who is required by law to educate his employees about this plan, if he possibly can afford it, is going to say: "Look, I'll share this with you." But he will do it depending on his profitability.

The Senator's program, while very thoughtful in its transition provisions for tax credits, they do expire after 5 years and there are just lots of small businesses that can't afford 8 percent of payroll.

The CHAIRMAN. Do you have any idea of the people in the gap, the 33 million who are uninsured right now, if your plan would go into effect, how many of them would ultimately be covered?

Mrs. JOHNSON. Yes, I do. Of that 33 million, two-thirds are working or dependents of workers. So the reach-down through the insured industry would help some of those, particularly the third whose incomes are above 200 percent of the poverty level. But some of the others may be covered, depending on how far down we drive the cost and how many employers participate in payment.

Then the community health clinics serve people—I mean, you can see it on the charts. All of their people for the most part are about up to 200 percent of poverty income. They have the right to serve people above that income. The functional fact is that is the group they serve.

So if we expand that, you see, we really do make access available. And these clinics are very nice. They have as a goal themselves to serve everyone, not just to be the health care provider for the very poor. They need to be able to serve the neighborhood, the area. And they win credibility that way. They become the family support that way. And they become the center of a variety of benefit programs that way. So it is very exciting to see what is happening there.

When you look at the fact that they serve the community health clinics—the community health clinics serve people up to 200 percent of poverty. Two-thirds of the uninsured are 200 percent of poverty. And the small business reform reaches down. Both of them say, and we did it with the numbers, if the amount of money in our bill would expand the community health center movement sufficiently so that you can say that we can serve well over the 33 million between the two approaches, it would be very exciting. It is very exciting to see how much could happen if we took those two steps.

And then how we would be able to look at the more complex issues of, is there a need for a premium subsidy to make sure everyone has access? We don't actually know that. My belief is that every WORLD town ought to have some income-related fee schedules. If you have that view of public health responsibility in that area, then you do eliminate Medicaid.

Reform Medicaid and you use it as a hospital component or a catastrophic care program. But that next round of reform, what we do about Medicaid and what role it fulfills, we just did these things, in about 1½ years or 2 years we would be able to see more clearly what the rest requires.

The CHAIRMAN. Mr. McCrery.

Mr. MCCRERY. Thank you, Mr. Chairman.

I would just like to compliment Mrs. Johnson on the work she has done. She not only serves on the Ways and Means Committee which has jurisdiction over much of what we are discussing, but also is heading up a task force of Republican Research Committee on which many of us Republicans are trying to assist.

We don't all agree on every facet of Mrs. Johnson's plan, but she certainly has been a tireless worker on that task force and has come up with some suggestions we can look at. So I would just like to compliment the gentlewoman on her efforts.

Mrs. JOHNSON. Thank you very much. I appreciate that.

It certainly is true we don't all agree on a lot, but it is surprising that every plan that has been brought forth, and Senator Mitchell's plan and my plan, do have some very important common elements. I hope I can be a catalyst for action now on those common elements. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much, again, Mrs. Johnson, for participating. We really appreciate it.

The next panel that we have is Karen Ignagni, who is the Director of the Employee Benefits Department, AFL–CIO; Diana C. Jost, who is the Executive Director of the Office of Government Relations of Blue Cross and Blue Shield; Greg Show, the owner and president of Electro-Management, Inc., of Palm Springs, CA, and a member of the National Federation of Independent Business; and Prof. Clark C. Havighurst, who is William Neal Reynolds Professor of Law at Duke University School of Law.

We welcome all of you here. Thank you for your patience. We appreciate your taking the time to come to the Budget Committee on what is obviously a very important issue.

We figured out in terms of future budgets, there are two issues that will predominate. One is interest costs and the other is health care costs. You have got to approach each of those.

Your statements will be made part of the record. You can read from them and summarize as you wish. Ms. Ignagni.

STATEMENT OF KAREN IGNAGNI, DIRECTOR, EMPLOYEE BENEFITS DEPARTMENT, AFL–CIO

Ms. IGNAGNI. Thank you, Mr. Chairman.

Thank you for the opportunity to testify and present the views of the AFL–CIO on what we view as one of the most critical issues for working people and their families.

In the coming months this Committee will struggle with an issue which has been the central question in health policy debates for decades, and that is what is the role that Government should play in health care. How you answer that question will determine the architecture of a proposed health care system, whether it should be employer-based with a safety net for those not in the work force, whether it should be a public system similar to Social Security or whether the system should be one of individual choice and responsibility.

As part of its deliberative process, we would urge the Committee to compare the cost and performance of the U.S. health care system to those of our industrial partners. While there are many different models throughout the industrial world, without exception all other countries provide their citizens access to adequate health care with Government-based reimbursement controls.

We urge the Committee not to be distracted by the myths of rationing excessive Government bureaucracy and inferior quality that have long been advanced by those who oppose reform. Taken together, the health care systems throughout the industrial world provide incontrovertible evidence that it is possible to provide coverage to all Americans far more effectively and at a cost that is measured and contained.

In comparison to our industrialized partners, the U.S. health care system fails the test of fairness and equity. We also fail the test of efficiency which is apparent to both consumers and providers who are frustrated with redtape and paperwork. Even those who seek to preserve the current system can no longer defend the excessive overhead and administrative costs associated with our fragmented system.

We believe, Mr. Chairman, that a nation that seeks to be competitive in the 21st century can no longer continue down this road. On a per capita basis, we spend 40 percent more than Canada, 90 percent more than Germany, and 125 percent more than Japan.

In short, the current crisis demands immediate action and the labor movement is united in its pursuit of fundamental restructuring of the system.

Although we have drafted specific proposals for your consideration, let me be clear that the AFL–CIO is not committed to any single plan. Instead, our objective is to maintain an open mind and work with all who share our goals toward the development of legislation that can be enacted.

We have three essential goals: to contain health care inflation; to provide all Americans access to care, and to overhaul administrative procedures.

To achieve the objective of cost containment we urge Congress to establish a national commission composed of consumers, labor, management, Government and providers to administer a single national cost containment program by doing three things. Negotiating rates to be used by all payors, establishing a target for the annual rate of increase in total health care spending, establishing a capital budgeting system to encourage the efficient distribution of capital, which will minimize the unnecessary duplication of equipment and reduce the large numbers empty beds still in the system.

To achieve the objective of universal access we urge Congress do three things:

Establish a core benefit package to which all Americans are entitled.

Require all employers, including the Federal Government, to contribute fairly to the cost of care for workers and their families.

Put an end to the patchwork quilt of Federal and State health care programs and establish one Federal program for those not in the work force, including the unemployed and those currently receiving competition within State Medicare programs.

Recently, there has been a growing interest in reforming insurance practices in the small group market.

While we support such long overdue reforms, the AFL–CIO believes that far more needs to be done, and that reforms should be developed by Congress, not the States, to assure uniformity across the country, and the most important, to contain costs. In short, nothing short of a complete overhaul of the system will solve our problem.

Finally, Mr. Chairman, to conclude, there is no doubt that there is real suffering going on out there. In our belief, nothing short of full-scale reform will solve our problems. We have reached the stage, we believe, where quick fixes no longer are possible, and where voluntary efforts on their own no longer offer promise.

For its part, the AFL–CIO is prepared to consider each and every proposal that purports to address the three issues of cost, access,

and quality. We are prepared to work with you and your staff to proceed toward these goals.

I thank you for the opportunity to testify.

[The prepared statement of Ms. Ignagni may be found at end of hearing.]

The CHAIRMAN. Thank you very much. You have to leave at 12:30?

Ms. IGNAGNI. Yes, sir.

The CHAIRMAN. Of the proposals, does the AFL–CIO support a single payor kind of approach to health care reform?

Ms. IGNAGNI. No, sir. We have not made any decision with respect to the payor issue. Our executive board has determined that rather than coming in with a full-blown proposal to present to Congress, it would rather offer the principles I reviewed this morning and look at the various proposals that would support and achieve those objectives.

Certainly if a single payor could pass both the Houses of Congress, we would not oppose a single payor. In fact, the Federation has had a long track record of supporting fundamental restructuring along the single payor, social insurance lines.

However, I do have to say that we are very concerned about the urgency of the problem. We want to stand ready to support each and every proposal that would deal with the health care inflation problem and set us on the road to universal access.

The CHAIRMAN. So basically, you have protected all of your options. You are saying the present system needs to be changed, you stated some goals, and basically you want to look at all of the different approaches.

As I understand it right now, all of the different proposals that have been introduced, you are reserving judgment on all of them at this point?

Ms. IGNAGNI. Yes, sir. And if you will allow me, with respect to the issue of the present system needing change, there is no doubt that we believe that. However, and perhaps it is difficult to glean from a piece of testimony, we do have some very specific proposals about the extent of that change.

For example, we have done some real thinking, and as you know we have had a series of hearings around the country or this issue and we believe that now is the time to start talking about setting up Federal regulations for intermediaries and all of those who purport to provide health care insurance coverage.

We also have identified a major problem at the bargaining table, which is that on both sides—labor and management—there are a great deal of proposals being offered to us that we are spending a lot of time and money analyzing in the name of so-called "managed care" What would be very effective is for Congress to take a look at the currency of the HMO law and begin to think about broadening and developing broad managed care health care legislation. It is absolutely clear that we need some clarification and some ability for the Government to impose a Good Housekeeping Seal of Approval on entities that purport to offer those services.

The CHAIRMAN. Thank you. Mr. McCrery, do you want to ask any questions before she leaves?

Mr. McCrery. No, Mr. Chairman.

Ms. Ignagni. Thank you, Mr. Chairman. Again, my apologies, Mr. Chairman, for having to leave.

The Chairman. I understand. Everybody is running crazy here today. Ms. Jost.

STATEMENT OF DIANA C. JOST, EXECUTIVE DIRECTOR, OFFICE OF GOVERNMENT RELATIONS, BLUE CROSS AND BLUE SHIELD ASSOCIATION

Ms. Jost. Thank you.

I am Diana Jost, Executive Director of the Office of Government Relations, Blue Cross and Blue Shield Association. We represent the 73 Blue Cross and Blue Shield plans nationwide. We cover 70 million subscribers. We are in the large group, small group, and individual market in every single State.

We are pleased that you invited the Blue Cross and Blue Shield system to participate in these important hearings. It is particularly appropriate that the Budget Committee is examining this issue because time after time our plans and our customers tell us that the No. 1 reason people do not have access to care is because of cost.

In my testimony, I point out that as a historical point, that the Blue Cross and Blue Shield organization was created in the depths of the Depression in response to the severe economic problems that we faced at that time.

Developments during the last several years have convinced us that fundamental reform in the health delivery and financing system is absolutely necessary. In my full statement, I lay out the historical context. And the reason that I do that, I think it is important in a public policy context to understand the supply and demand forces that we have set in motion over a series of decades.

It was our public policy to enact the Hill-Burton program to finance the National Institutes of Health, to issue health manpower grants, and we set in motion a supply strategy that significantly heated up the engine.

In the mid-1960's, we enacted public policy on the demand side when we passed the Medicare and Medicaid laws, which stoked the engine even further. And all of that was happening at a time in our history when we enjoyed double-digit economic growth and, in fact, health care inflation was moderate, about 7 percent.

We find now, though, that these demand and supply decisions fueled inflation. Our demographics have changed significantly. Economic growth has slowed, and health care expenditures have increased, resulting in very significant problems of affordability and, therefore, increasing numbers of Americans that lack health insurance.

In my testimony, I lay out in some detail an action taken by the board of directors of the Blue Cross and Blue Shield Association in February of this year, which they unanimously approved to reform the insurance practices in the small group market. I would be pleased to answer questions on this in the question and answer period.

It is important to understand that many of these reforms would not reduce costs. That is something people need to understand as we go through this debate.

The position we have taken is an aggressive position on our part which calls for very substantial reform of the insurance industry, both the underwriting practices, as well as the rating practices. But beyond that, we in Blue Cross and Blue Shield are committed to a broader challenge of assuring affordable coverage for all Americans within our pluralistic health care system. And we do endorse three strategies.

One is universal access for all Americans through a combination of public and private programs. Second, we should drive to make benefit coverage more affordable. And third, we have to assure a well-functioning and competitive insurance market.

Our universal access strategy should be related to the employer base system. Most uninsureds, as we know, are workers or dependents. We need to take a fresh look at how we use tax subsidies for that structure. We need to look at the question of continuity of coverage during lapses of employment, and how that can be solved. We need to look at efforts to improve affordability to go a long way to easing the burden on the employer.

I would say the affordability strategy, our second point, is a tough one. We need to strike at the heart of the price utilization equation by more effectively managing the number of services provided, and to assure the quality of those services.

We need to look at benefit design that balances the competing needs of adequate protection, affordability, and incentives for appropriate services. We need to look at ways to streamline paperwork requirements placed on providers, and we need to engage all the players and think about the nature of the incentives that drive the system and how to change the behavior.

In conclusion, what I would point out is there has been a lot of discussion recently about administrative costs of our current system. Mrs. Johnson mentioned it also.

Many people point to the administrative costs of insurers as a target for cost savings, and question the fundamental value of a private health insurance system. I would say on behalf of my organization, the Blue Cross and Blue Shield Plans, they are very proud of our record in providing an average of 90 cents in benefits for every $1 in health benefits premium.

Our third point is to assure a well-functioning competitive insurance market, where insurers compete on the basis of service and cost effectiveness rather than on the selection of risks.

In conclusion, Mr. Chairman, I would acknowledge that the problems of the uninsured population are, indeed, very serious. It demands a concerted effort by both the private sector and Government. And we, in our organization, stand ready and willing to move ahead with Government to develop a series of well-planned, coordinated steps to assure access and to control costs.

The CHAIRMAN. Thank you very much.

[The prepared statement of Ms. Jost may be found at end of hearing.]

The CHAIRMAN. Rather than break into the testimony of the other two witnesses, I think what I will do is recess now. We have to vote. I believe there are a couple of votes, and we will reconvene after the next few votes. Again, I apologize. Hang on, we will get to you.

Mr. MCCRERY. Mr. Chairman, I may not get a chance to get back, so if you don't mind, I will interject at this point, because it follows what Ms. Jost has talked about.

Something that has struck me, in all the testimony we have heard this morning, is that not much has really been said, or in my opinion offered to get to the core of the problem, which is escalating health care costs.

We have heard proposals about how we are going to give access to the working poor, and how we are going to mandate employers, and how we are going to create a Government program, but nobody has really talked about getting the cost of health care down.

Ms. Jost has, I think, very generally, and I look forward to reading your testimony to see if you get into it more particularly, but I think she has hit on the problem, and that is that many of the proposals we are hearing in my opinion not only will do nothing to get health care costs down, they may even have the reverse effect of further escalating health care costs.

Blue Cross, as you stated, was invented in the Depression era to cope with a specific problem that was occurring in our Nation in the Depression, but unfortunately, like a lot of other programs that are created to affect particular problems at a particular time, once they are in place we ignore them and let them keep going and they get bigger and bigger and bigger, and before you know it, our whole medical system is driven by this thing that was created in the Depression and has contributed to the problem of escalating health care costs.

Until we get to the core of the problem, which is how those services are provided and how they are paid for, and get the incentives back in the program to get health care costs down and controlled, I don't think we are going to do much for the budget of the United States or for access and quality and cost.

I just wanted to get that in while I had a chance.

The CHAIRMAN. Thank you, Mr. McCrery.

We will adjourn briefly for this vote and reconvene as soon as the votes are completed.

AFTER RECESS

The CHAIRMAN. If I may ask the panel to reassemble here, I apologize for the delay. We are working on the foreign aid bill. We have amendments under the 5-minute rule. Unless you get unanimous consent to package those votes, they will come fast and furious. I thought I would come back and hear the testimony. Mr. Show.

STATEMENT OF GREGORY SHOW, OWNER AND PRESIDENT, ELECTRO-MANAGEMENT, INC., PALM SPRINGS, CA, AND MEMBER, NATIONAL FEDERATION OF INDEPENDENT BUSINESS

Mr. SHOW. Good afternoon, Mr. Chairman. I am Greg Show. I ask these statements and the enclosures be submitted for the record.

Electro-Management is owned and operated by Greg and Vicki Show. We specialize in electrical construction and have been doing so for almost 13 years. We have grown from a small, four-person shop to currently employing 25 to 40 people, depending upon the construction market and our work load.

In 1987, in an effort to attract and retain the best employees in Palm Springs, we decided to expand coverage for most of those employees. In order to control costs and provide incentives to employees who remain with our company, we phase in the company's contribution over a period of time.

When a new employee starts with us, they become eligible for insurance after 30 days of continuous employment. After 30 days, they can participate in our health plan at their own expense. After 6 months, we pay 50 percent of the employee's premium, and at the end of 1 year's continuous employment, we offer to pay 100 percent of the premium.

From the employee's standpoint, this practice works well, because they can be insured almost immediately and are rewarded for length of service. But it becomes very burdensome to the company due to the increase in insurance costs.

One problem with the arrangement is that after 6 months, new employees are receiving increases in salaries and don't even realize it. In the past, health insurance premium—in the past, the health insurance premium increase alone was 10 times the amount of our increase in profits, sometimes more than 10 times.

Further, many of our younger employees tell me, I would rather have the money and forget about the insurance. That poses a second dilemma for us. We do not give extra money in lieu of insurance, because we believe that all of our employees should have insurance if they qualify.

The bottom line is simple. We provide health insurance with trust in the long run that it will make us more competitive, because we can and do attract better employees in an industry where currently maybe four out of five companies do not provide insurance. Health insurance is a valuable fringe benefit for us that helps us stick out in a crowd. We also feel that it is our obligation to provide this benefit.

The problem for us and other small employers, however, is with the rising cost of insurance.

Mr. Chairman, I also feel compelled to tell you that I oppose the pay-or-play health care insurance proposal for primarily the following reasons:

The first one is, if implicated, our business would drastically be scaled down in order to be more affordable to us, thus costing jobs. I am completely opposed to Federal mandates. I can barely keep up with ever-changing rules and regulations as it stands right now.

The second reason is, we do not believe that the Federal Government should be involved in providing any type of insurance program, especially mandated through business. If the Government is to assist in changing the insurance problem, I believe it should begin by mandating tort reform at the State level.

The third reason is, given the current state of the Federal budget, I cannot imagine how they would propose to initiate and control a giant fund such as the one created by increasing payroll taxes. There is not much faith in the spending habits of the Federal Government.

Fourth, I do believe that if a Government body is going to have a hand in health insurance issues, it should be at the State level, without mandating increased taxes on employers.

Mr. Chairman, I want you to know from me to you that it is a tough road out there right now. My business is down. I know others are, as well. That is why you probably understand when business owners say they have to cut back. I can tell you that when you get nothing but increase after increase for unbelievable amounts of money for health insurance, the first thought is to cut the insurance first.

As I said, we now have currently about 20 employees and over half of which we pay insurance for. It would be catastrophic to them and to us to cancel insurance benefits. My company will not do that. But I can tell you, there are many of my business colleagues that are currently considering just that.

There there are those of us, or those who want to purchase insurance for their employees, but are pushed away by the potentially fatal cost increases that will surely and shortly be forced upon them.

Sir, our people are very important to us. They are our most valued asset. We want to take care of them the best way that we can for their loyalty and their dedication.

I think the business world sympathizes with the job you have at hand, but we must do something fast and stop the procrastination. We need to start somewhere, even if your first-out proposal is not totally 100 percent successful, at least you will have begun the task.

Thank you for inviting me, Mr. Chairman. It was an honor.

[The prepared statement of Mr. Show may be found at end of hearing.]

The CHAIRMAN. Thank you very much, Mr. Show.

The CHAIRMAN. Professor Havighurst.

STATEMENT OF CLARK C. HAVIGHURST, WILLIAM NEAL REYNOLDS PROFESSOR OF LAW, DUKE UNIVERSITY SCHOOL OF LAW

Mr. HAVIGHURST. Mr. Chairman, let me start by saying that I strongly agree with the premise of this hearing, namely, there is a direct link between the high cost of state-of-the-art medical care and the accessibility to health services for the American people. The high cost of standard medical care greatly limits our ability to provide publicly for those citizens whose economic circumstances do not permit them to provide for themselves. Moreover, many

Americans who could afford to purchase basic health coverage have been priced out of the market by the unavailability of low-cost options, thus adding to the number of uninsured for whom some provision must be made. This Committee has wisely noted the crucial connection between cost and access. I welcome the chance to discuss the subject with you.

The focus of my testimony is the current state of the law affecting the purchasing of health care. My thesis is that the health care industry is currently subject to a seldom-recognized kind of overregulation that forecloses the offering and implementation of low-cost health care options that would otherwise be available to both public and private purchasers. If low-cost health plans were available, many citizens who are currently uninsured could, with appropriate subsidies provided through the tax system, provide adequately for themselves. In addition, Governments—both Federal, State, and local—could more readily discharge their responsibility to the remainder of the uninsured population at a reasonable cost to the taxpayer. Thus, there are good reasons to identify and try to remove regulatory barriers to responsible economizing in the purchasing of health services.

The kind of overregulation to which I want to call the Committee's attention is not the same regulation that many other commentators have blamed for the high cost of health coverage. I do not disagree, however, with these commentators' view that State laws prescribing the content of private health insurance policies—so-called mandated benefit laws—contribute to higher costs and to reduced access.

But my remarks today are directed to a different and less widely appreciated kind of regulation, which also precludes responsible economizing not only by health care consumers and their agents, but also by public programs for financing health services. The overregulation that I am concerned with is not statutory. Instead, it is imposed by courts and by the legal system through malpractice litigation and through lawsuits against third-party payers over coverage issues. By prescribing unrealistic legal duties for health care providers and for public and private health plans, and by simultaneously threatening not to give effect to the terms of private contracts that might specify alternative obligations, courts have blocked some of the most promising avenues to economizing in the purchasing of health care.

Although the problem of defensive medicine practiced under the compulsion of the law of medical malpractice has been widely noted and is a reflection of the overregulation I am talking about, the larger problem of judicial overregulation has rarely been identified with the clarity it deserves. In my view, the legal system is forcing Americans to purchase either coverage entitling them to first-class, state-of-the-art medical care or no coverage at all. Now, for most of us, that is merely a Hobson's choice—we take the one option that is available. But for many others, the absence of options means going bare in a potentially cruel world.

Mr. Chairman, recent years have seen many new techniques for economizing in purchasing health care emerge, but there still remains a combination of circumstances and legal rules that inhibits public and private attempts to achieve efficiency in the use of re-

sources for health care purposes. One crucial problem to which I want to call the Committee's attention is the limited utility of private contracts as instruments for specifying standards and rules to govern particular relationships between consumers, payers, and providers. Vital terms of these relationships are still prescribed—despite all the efforts at managing care—not by the parties themselves, but by the courts borrowing standards wherever necessary from the medical profession. In litigation initiated by patients either against providers for malpractice or against payers to compel coverage for particular services, the legal system regularly gives professional norms and standards—even ill-defined or poorly conceived ones—virtually the same mandatory effect that official public regulations would have. Because the law effectively precludes health care consumers from choosing to have their care governed by other standards, it effectively denies them opportunities for responsible economizing.

Normally, of course, private contracts are the means by which purchasers specify in advance the precise characteristics of the goods or services they are purchasing. As things now stand in the health sector, however, consumers and their agents are unable, as a practical matter, to authorize by contract providers to omit or payers not to pay for services that are of doubtful or only slight value, if those services are seemingly mandated by professional standards. Most lawyers would tell you that contracts that purport to vary the standard of care applicable to health care providers—or to let health care plans off the hook for care that seems to have been prescribed responsibly by the doctor—would face rough going in the courts.

Mr. Chairman, the professional norms and standards that generally bind physicians and payers in the current legal environment are unsatisfactory from virtually every point of view. They are hopelessly vague and unpredictable. Because they are vague, they induce physicians to practice what we call "defensive medicine," which may entail expenditures far beyond what the law would actually require—as doctors try to avoid getting entangled with standards they do not understand and cannot find written down anywhere. The elasticity of professional norms may also make payers feel they have to pay for everything a doctor recommends unless they can show a very clear reason why that prescription was inappropriate medically. In other words, the burden of proof is always on the payer, and it is a very high burden of proof once you go to court.

And even when the professional standards are relatively clear, they may not be efficient. They may be quite unsuitable for many purchasers. Having emerged in a market that is distorted by third-party financing, the standards of customary medical practice do not adequately take into account the marginal tradeoffs between benefits and costs. Moreover, professional standard-setting organizations, to whom we look for, say, practice guidelines, have no incentive, nor are they likely voluntarily, to set standards that economize in significant ways. And because cost considerations are not weighed very heavily in medical decisionmaking at any level—given insurance and all the other things that prevent costs from being considered in making choices—Americans tend to consume

many more medical services of very doubtful use than they would buy if they had good information and unrestricted opportunities to economize.

Mr. Chairman, what I am offering is an explanation for the cost problem that is very different from these that you normally hear. I am telling you that it is the legal system that is telling the American consumer he must buy a Cadillac or nothing. Many people, unfortunately, have had to choose nothing. That is a major cause of the access problem that concerns us.

Now, I want to suggest that we need to do a number of things to make more options available in the private market. The testimony that I submitted proceeds to discuss some ways in which consumers might economize if private contracts were available as mechanisms whereby they could write the deal that they want as opposed to taking some version of the Cadillac that the industry is required by law to provide.

Let me take you briefly through some things that consumers might do. First, I would like to see experimentation with contractual reform of malpractice rights. It is quite feasible for private contracts to introduce the same kinds of reforms that some State legislatures have introduced and that many in Congress would like to see adopted nationally. But that could be done privately by a health plan that agrees with consumers that it and its providers will not pay damages beyond a certain point.

One could imagine many other contractual reforms of existing tort rules that would minimize the impact of tort law on particular providers and consumers. I can imagine a contract that would provide not for ordinary tort reform but for an entirely different kind of compensation, no fault compensation, compensation without regard to fault whenever certain injuries occur. Such an arrangement could be adopted privately by contracts displacing the tort system. I think we should be inviting reforms of this kind.

Most important, private contracts could clarify or modify the very costly standard of care—the professional standard of care that applies in malpractice cases or the standard—again, a more or less professional standard—that defines a payer's obligation to pay for everything that is medically necessary.

Customers need the freedom to economize, to decide not to buy so much, and to commit themselves to a plan that doesn't give them all that they might expect to get under the professional standard that generally prevails today. In this connection, Mr. Chairman, practice guidelines strike me as offering an exciting new opportunity. One can imagine practice guidelines developed by various groups throughout the health care sector that wouldn't necessarily agree on every point. Such guidelines might present different approaches to different problems, some more economical than others. In other words, some practice guidelines might incorporate cost considerations that the medical profession's own guidelines are unlikely to incorporate. To my mind, selected practice guidelines could be incorporated by explicit reference in private contracts and would then become the standard that would govern the payer's and the providers' obligation. In a tort suit, the physician could cite those guidelines as a defense rather than having to be judged with reference to the customary practices of his profession.

When Mr. Waxman talks about guidelines, as he did this morning, he is thinking about a single set of guidelines to govern all medical care in America. I think that would be regrettable. It seems to me the better idea is to allow reliable private groups—with Government participating as it already does through the Agency for Health Care Policy and Research—to produce distinctive guidelines and make them available for those private interests that choose to adopt them. Guidelines would then represent a new technology allowing consumer groups to exercise choice—we make the choices they have been denied by practical circumstance and by the judicial hostility to private contacts in the past.

What I see in the guideline movement is an exciting opportunity for economizing at the private level in ways that have not been possible before. I think we should encourage this movement with this opportunity in mind. This could solve many of our access problems and put us on the road to finding truly efficient standards of medical care that we have not had up to now.

Let me say just a couple of things about what Congress might do to advance these objectives. What I have been talking about up to now is what private parties might do in contacting for care. Senator Domenici introduced a bill a week or so ago that I find quite exciting. It is S. 1232, Mr. Chairman and I will submit a copy for the record. The main purpose of the bill is to require all medical malpractice cases that the Federal Government can reach be brought in alternative dispute resolution forums rather than in court. Athough I would like to call your attention to that provision, there are also provisions in the bill that contemplate contracting for an alternative standard of care. In other words, private parties, private health plans could establish a standard of care different from that prevailing in the particular State. The Domenici bill also mentions practice guidelines specifically, and suggests that they might provide the standard of care that would govern whether a malpractice suit would succeed or not. Finally, the Domenici bill also contemplates the possibility that a private health plan might adopt a no-fault compensation scheme instead of staying with the fault-based system.

Finally, Mr. Chairman, my testimony also suggests that need for a vast public educational effort. I would suggest, in fact, the creation of a Presidential Commission, comparable to the Commission on bioethics that President Carter appointed back in the 1970's. The purpose of a new Commission, as I see it, would be to publicize the many emerging opportunities to economize safely and rationally, in purchasing health care. I see a need to call consumers' attention to the fact that the professional standard is very high, probably more costly than is a good investment for most Americans; and then to encourage people to explore other ways of buying care.

The other purpose of this Commission would be to legitimize both private and public efforts to buy a little less in order to save a lot. I see a need to begin to make people comfortable with the idea that they might buy less medical care than the medical professional thinks they should have.

In all the talk I have heard today—I think this was Mr. McCrery's point earlier—cost control was either ignored or it was suggested that you can have it without sacrificing anything. It

seems to me that one has to be aware there are significant tradeoffs here. Until we are willing to face the fact that we may have to give up some marginal benefits—may have to take some small risks—in order to save money for other purposes, we may not be able to address the cost problem effectively.

Lost containment is a difficult problem in any event. It seems to me that it can best be addressed in the private sector and in private contacts. Practice guidelines may give us for the first time the tools we need to finally begin to make real headway in finding places where we can economize safely. I strongly believe that people must be given tools with which to solve the cost problem for themselves without looking to Government to decide what medical care is best for all of us. Economizing tools are an essential first step in addressing the access problem that has become so severe today. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

[The prepared statement of Mr. Havighurst may be found at end of hearing.]

The CHAIRMAN. Professor, let me ask you, as an attorney myself, I am trying to figure out how you would define a standard of care into a contract.

Mr. HAVIGHURST. I tried to write one once. It was an interesting thing to do. I said for a HMO, for example, that the plan's and its doctors' responsibility to the patient was to be reasonable and prudent in treating him; but not necessarily to follow customary practice. You know, if you know your tort law, that the courts usually a doctor to do what is customary in the profession. As we know, however, a lot of things that are customary may not be worth doing. There really is a lot of waste out there, an HMO ought to be free to proceed otherwise. My draft contract want on and had a few other provisions that tended to legitimize departures from custom. I think in court they might have helped.

I think that in the long run—it is too early to be sure—the practice guideline idea may have even more potential. Using guidelines we could be quite specific about how each condition should be treated.

The CHAIRMAN. What do you actually do then? Look at a condition like you know, a person who has a stomach problem or what have you, and then dictate what would be a reasonable number of X-rays? What would be a reasonable——

Mr. HAVIGHURST. Yes. I am not enough of a physician, but I have talked about this enough with the people working in the guideline movement who know the progress and potential in this area. They seem to be willing to explore the feasibility of actually putting this much weight on guidelines. They do not deny that it might work in time.

But the thought would be that the plan could undertake in the contract to adhere to the guidelines issued and maintained by a particular organization. And that would then become the standard for judging both the payers' obligations and the provider's obligations. I don't suppose anyone would think you would go to the contact every time that a patient had to be treated, but it would create a ballpark, giving a sense of just how much care is called for. It

would leave out some MRI scans, and other things that would probably be provided now because doctors fear that that is what the courts would expect.

This is an idea I think that has real potential, but it also needs to be tested and worked with.

The CHAIRMAN. Yes. I am sure.

Mr. HAVIGHURST. The important thing is——

The CHAIRMAN. I can't imagine if you are following a certain standard with regard to negligence and you have a document—it does depend upon almost each individual case. Each case does vary. You know diagnosis varies. The doctor has to assume, wait a minute, I may need to have an additional scan here; I may need additional X-rays in order to make a judgment. I guess it is so difficult.

Mr. HAVIGHURST. I think, as in any ongoing relationship such as we would have here, there would be a reasonable amount of flexibility. I don't think, as I say, you go to the contract every time. I think it is important to think about these guidelines as setting a tone for the enterprise, you would also want to encourage your physicians to be more than just cooks following a recipe. The important thing is to take away the malpractice threat at the margin and to give payers a better basis for limiting what they will pay them.

The CHAIRMAN. I have another vote that is on and a few minutes left.

Mr. Show, I guess the question in my mind is that, you know, recognizing the problems that businesses are facing out there, I guess the question is, Where do we go to pay for the kind of system that would be able to cover employees at a minimum cost? Where do we go? Who is going to pay for it?

Mr. SHOW. I believe that if you control the costs of health insurance, just like the Professor was just talking about, the people I work with, you know, in the construction industry, anyway, in an effort to get the good employees and the reliable people, they are going to supply and provide those people with insurance, and there would have to be—I think at the State level, a fund or a tax at the consumer level to where everybody helps pay for the people that fall through the cracks and don't meet those qualifications.

I know they would—that they would furnish insurance, but they are just right now——

The CHAIRMAN. And help pay for that insurance?

Mr. SHOW. I don't know what you mean.

The CHAIRMAN. In other words, there would be an employer contribution. You would make a contribution?

Mr. SHOW. No, no. The contribution would be—for the—the—the people that fall through the cracks would be on an increased tax. In California, we had the earthquake tax to help out that.

The CHAIRMAN. In other words, you would go to the general public?

Mr. SHOW. Absolutely. So everybody is responsible for their own individual insurance.

The CHAIRMAN. All right.

All right. Again, thanks to all of you. I really appreciate it. I wish we had more time. We have a crazy schedule. I do appreciate

e testimony. It is very helpful. It will continue to be helpful to us we try to look to the future.

We will proceed with this as soon as I—we have another vote on w. It will probably be followed by another vote. I will keep ming back. We will try to get this done incrementally, if we nnot get it done all at once.

After Recess

The Chairman. The Committee is continuing its hearings with gard to health care costs and access. We now have Humphrey aylor, President and Chief Operating Officer of Louis Harris & ssociates, to get the feel of the public's mood on this issue.

We apologize for the delay, but you have been up here enough nes to know what the process is. Welcome, and you may proceed th your statement.

STATEMENT OF HUMPHREY TAYLOR, PRESIDENT AND CHIEF OPERATING OFFICER, LOUIS HARRIS & ASSOCIATES

Mr. Taylor. Thank you, Mr. Chairman.

You should know that for the—this country, we, the Harris firm, ve not done any polling for political candidates since 1963, when e candidate who lost to Mr. Harris' client told the media, very accurately, that they would not have him to kick around any ore.

However, 30 percent or more of all revenues in the United States me from our work in the health care field. Our health care cli- ts include drug companies, insurors, HMOs, hospitals, founda- ns, universities and Federal and State government. So I should arn you I may be a hired gun for those with a vested interest in eping the $600 to $700 billion we spend on health care growing a rapid rate.

The public wants four things from the health care system: Acces- ility, quality, affordability, and one thing that is not talked out much, security.

People want easy access to reasonable quality care at an afford- le cost, and the peace of mind that they won't lose their health surance and that they won't be wiped out financially by their alth care costs.

On quality, the system does reasonably well. Most people are ry or somewhat satisfied with the quality of care and the services at they use.

On accessibility, there are two different stories. On the one hand, e great majority are satisfied with their own access to care. On e other hand, there is a widespread and, of course, accurate per- ption that many people do not have health insurance and many hers are underinsured. 60 million people have no insurance at me point in time.

Overwhelmingly, people say that is unacceptable. Virtually ev- yone, 97 percent, now believes that health insurance is a right to nich everyone should be entitled, and obviously, many people n't have it, including many working people and their depend- nts.

On cost, there is, of course, much dissatisfaction, with out-of-pocket costs to the consumer, with the cost to the taxpayer, and with the rate of inflation.

In that context, there is much talk about the trend toward managed care, but contrary to what you might imagine from reading the papers, the fastest trend is not the trend toward managed care, HMOs or PPOs, it is actually the trend toward greater cost sharing, which is really a euphemism for cost-shifting by employers to their employees, and one unintended consequence of this cost-shifting is that it is fueling public dissatisfaction with the system and increasing the demand for radical change in the system, and indeed support for Government, on both universal coverage and cost containment.

Higher out-of-pocket costs are becoming a considerable barrier toward getting care. In a survey conducted by an organization called the Gallup poll, 29 percent report they put off getting some kind of health care which they believed they needed because of the cost during the previous 12 months. That is a large number.

Now, in addition to cost, access and quality, I would like to say just a word about the fourth criteria, security. Fear of losing one's health insurance is now a major concern. In one poll; fear of losing one's insurance came up as an even higher concern, a bigger concern than the out-of-pocket cost of care.

I might add that concern about the lack of long-term insurance for nursing home care and home care is also increasing as the public becomes better informed on what Medicare does not pay for, and as more middle-aged Americans worry about their own parents.

I believe that the public attitudes to the health care system are directly determined by these four criteria, and on three of the four, cost access and security, it measures up badly to public expectation, and things are getting worse.

On only one of them, quality, is the public generally satisfied. If you remember, our research that we have done convinces me that over the next few years, numbers of uninsured will continue to grow, costs will continue to rise rapidly, as will fear of losing our insurance.

We have also done a number of surveys of employers, and these surveys point to—paint a picture of employers as cranky, confused, aimless, and forgive me, spineless. There are some honorable exceptions, but not many. They are cranky because their costs are going up at such a high rate.

They are confused because they don't understand why this is happening to them. Most of the solutions peddled to them haven't worked. And they are aimless in that most of them have no real strategies for dealing with the problem.

They are more concerned to limit next year's increase than in addressing the underlying causes of their problems, and they are, I fear, spineless in that even when they know some of the things they should be doing, when they understand what types of managed care work best, they are very reluctant to take these somewhat tough decisions.

Most employers are more part of the problem than the solution.

The CHAIRMAN. Sounds like Congress as well.

Mr. TAYLOR. I might add that surveys of small businesses do not suggest that many small businesses who currently do not insure their employees or dependents will do so even if we can reduce the cost of health insurance for small businesses, even if we have substantial small business reform.

I fear that if you don't mandate it, they won't do it. I talked earlier about the four factors which shape public reaction to the health care system, but what do people think of the system? To put it bluntly, they think it is a disaster. Two Harris surveys have shown that the American health care system is exceptionally unpopular, both in absolute terms and when we compare it to systems in other countries.

Our surveys of the public in 10 different countries asked which of three phases best describe the different health care systems there. The proportions of the public in these countries who believe that the health care system works pretty well varies from 56 percent in Canada to a low of only 10 percent in the United States.

Most Americans, 60 percent, replied that there are some good things in our health care system, but fundamental changes are needed to make it better, while more than a quarter take a more extreme position, that it has so much wrong with it that we need to completely rebuild it.

It is not only uniquely expensive, it is also, along with the Italian system, the most unpopular. Americans then are almost unanimous, and 9 out of 10 is pretty unanimous, in believing that fundamental reform is needed.

But they, like all of the experts, and you have heard some of them today, are much less certain in what shape reform should take. The problems are pretty obvious, the solutions are not, and one is reminded of H.L. Mencken's comment that for every complex and difficult problem, there is a simple solution, and it is wrong.

Most people support Government-financed health insurance, Canadian-style, and also a plan for a mandatory employer-provided coverage with the Government looking after everyone else, as was originally proposed by President Nixon back in 1973.

If forced to choose between these two alternatives, a plurality but not a majority favors a universal Government-financed option. You have a chart at the back of my text which shows the numbers. But I would warn you this could easily change up or down as the debate develops over the next couple of years.

You may also know that the polls have been looking at public attitudes to various forms of national health insurance for over 40 years, and they show that support for it today in whatever form one asks the question, is stronger than it has ever been before.

As you may have guessed by now, I haven't always lived in New York City. In my professional work at Harris, I have studied in considerable detail the many ways in which health care systems around the world, particularly Canada, Western Europe, and Japan, operate, and I have written at some length on the subject.

There is, to me, absolutely no mystery on the question of why the U.S. system not only fails to cover all its citizens, but also costs so much more than other systems. Among them, many factors

which are literally or almost literally unique to the United States are the following:

The malpractice and tort system, the very high administrative costs you have heard about in the GAO report, the extraordinarily high fees we pay doctors and hospitals in this country, much higher than in other countries, the high prices Americans pay for drugs, second only to those paid in the Netherlands, much higher capital spending on hospitals and equipment, the number of tests and very expensive procedures performed, and there is now a growing body of evidence that many of these are inappropriate or marginal, the very high ratio of specialists to primary care givings, again unique to this country, amount of care we provide to patients in the last 30 days of their lives, and the enormous expense of that cost which many would argue is not even humane, the high level of unused hospital capacity, the 800 and growing State mandates of what insurance must cover, the level of fraud by providers and patients, estimated at 10 percent by the health insurance industry, the absence of expenditure caps or budgets for providers or payors, which every other country has.

It is, I believe, the high cost generated by all these uniquely American attributes which makes it so difficult to find the extra money to pay for universal coverage.

Fortunately, I believe the public, if not the interests involved, would favor changing many of these factors. Given this list, why haven't we done anything to control costs? As Senator Mitchell said, we need a consensus, not just on the fact that we have a problem to fix, but also on what the solutions are to the problem, and even more difficult, on how to pay for those solutions.

And to date, the only consensus that we have is that we have a problem of high costs and poor insurance coverage. The public, business, health care industry, doctors, all disagree on the causes of the cost problem, and therefore on the solutions. Doctors wouldn't mind at all if health care costs keep on growing. They would welcome universal coverage, but they want to be left to practice medicine with less interference from Government, employers and insurors.

Business leaders tend to favor changing financial incentives and penalties for both consumers and providers, that is, doctors and hospitals, to make them behave more cost-effectively.

Many economists feel we need to limit the use of more expensive, new technologies and find a better way to ration care, which we do now, without admitting it, but this would be based on benefits and costs.

The public tends to favor Draconian price controls of hospitals, of doctors, and of drugs. But as opposed to substantially increased out-of-pocket costs, or to the overrationing of expensive technologies, or substantially higher taxes.

We do have a consensus that in theory everyone should have reasonable health insurance. The difficult part, while we still have a very long way to go is to agree on how to do that and how to pay for it. Although the public overwhelmingly supports the kind of mandatory employer coverage that is being proposed by Senator Mitchell and others.

I think the pressures to do something are growing all the time. There is, we have found in our surveys, a growing belief that a major Federal Government initiative will be needed, not because people like or trust the Federal Government, I am sorry to say, but because they don't think anybody else will do the job.

One question we have looked at is how health care and specifically reform of the health care system rates as a political issue. The answer, briefly, is that it has potential to be a major issue, but has not yet achieved that status. Compared to the major economic issues or to other social issues such as education, crime, the environment, or drugs, relatively few people spontaneously cite health care or health care reform as a major issue.

I actually believe that if heavyweight political leaders in general or one in particular wanted to make this major issue—and these hearings today suggest that maybe some of you do—that you could do so.

There is a strong and growing concern about costs to the consumer, to the taxpayer, and of course, to the employer, all of which I am sure, from the data we are looking at, are going to get worse.

Almost everyone believes health insurance should be universal, yet the number of uninsured is still growing. More and more people are concerned that they may not have health insurance when they need it. Overwhelmingly, people believe fundamental changes or more are needed.

If I were still in the business of advising politicians on how to run their campaigns—and, thank goodness, I am not—I would advise them that there are a lot of votes to be won by a strong health care reform bill, even if it is opposed by some powerful interests and PACs, as it would be.

Meanwhile, in the absence of substantial reform—and I don't consider malpractice reform or the voluntary small business reform we are talking about as substantial—in the absence of substantial reform, the problems of high cost, poor access, and insecurity, I fear, are going to get worse, all of which will make this an increasingly important political issue.

Sadly, I fear that as these problems get worse, it will take a long time before Washington is able to implement, as opposed to debating, a viable set of solutions. I hope I am wrong. Thank you, Mr. Chairman.

[The prepared statement of Mr. Taylor may be found at end of hearing.]

The CHAIRMAN. Thank you very much, Mr. Taylor. Your testimony is helpful in trying to pull together the different pieces that obviously concern the public on this issue.

I guess the one thing that has always occurred to me, and I don't know if you can get at it, is the question of—and even Senator Mitchell admitted it—that there is a kind of public desire for drastic reform that goes to a single-payer system that kind of slices through this huge bureaucracy and problems that they see in the system. There is obviously an attraction to the more simple approach to try to deal with what is a very complex problem.

I guess the question in my mind is, If the public in a single-payer approach, as we debated that kind of possibility, began to realize

that there had to be limitations, rationing, severe cost controls, and impact in terms of the choices that they would have or have under some of the existing insurance systems, what do you think would be the reaction then?

Mr. TAYLOR. If I may divide it into two issues, one is the single-payer versus the multiple issue; and the other is the rationing issue.

It is interesting, if you look at one of the tables attached, the last but one, public reactions to three alternatives for the future, you will see over the last 18 years we have seen a decline in support for the present system and a substantial increase at the bottom in support for a comprehensive national health insurance program paid for by Federal taxes, which is a shorthand for the Canadian system.

If this trend continues, what you are seeing is a long-term trend toward a single-payer as being the preferred mode for the public, although as I mentioned earlier, the public is delighted by and supportive of a multiple-payer system with employer-provided insurance mandated.

If you turn to the final table, however, where we put the same question to a lot of different leadership groups, including some Federal legislators and their aides, we find, with one exception, and that's union leaders, relatively little support for a Canadian-type system and much more support for a multiple-payer system with employer-provided insurance and the ability to choose what kind of benefits they provide.

As far as the rationing issue is concerned, Americans don't believe we need to ration care in order to contain health care costs. Most of the leadership groups we have surveyed believe we do need to do that. The American public thinks that a reasonable health insurance should cover most things and that the man in the street should be entitled to the same coverage as a millionaire. So that's a really tough one for the public.

The CHAIRMAN. That was my thought, because one of your elements here is, in addition to accessibility, affordability, and security, is quality; and the American public might react very adversely to what they might determine to be a restriction on quality by virtue of just sheer cost-containment.

I mean, people now complain to me about the DRGs that require a certain level of presence in the hospital. They complain that they get released too early. It is going to be an interesting contrast in terms of trying to walk those fine lines.

Mr. TAYLOR. Unfortunately, if I may, the case of the one person who is deprived of very expensive, high-technology tests dies when they aren't able to obtain a $300,000 bone marrow transfer, that makes the headlines and gives the politicians involved a lot of grief.

The fact that we don't provide low-cost, low-tech care to hundreds of thousands or millions of poor, pregnant women or well-baby care to their children when they are born, that goes unnoticed.

The CHAIRMAN. All right. Mr. Payne.

Mr. PAYNE. Mr. Taylor, thank you very much. Your testimony is very enlightening.

I would like to ask you about the graph on page 5 of your testimony. You have inscribed a line showing a trend among most nations that, as per capita health spending increases there is a greater degree of public satisfaction with the health care system. However, the United States falls completely off this trend-line.

Mr. TAYLOR. Almost off the map.

Mr. PAYNE. Is there an optimal point beyond which you can't spend more money without getting more satisfaction? Have we exceeded that?

Mr. TAYLOR. No, Congressman. The answer is that the way we spend money isn't responsive to what the public wants.

So it is not that we spend so much money which make it unpopular, but the fact that we don't spend money on the things the public thinks we ought to have, such as universal access.

Mr. PAYNE. Affordability is also a big issue, as insurance costs for working people continue to increase.

If we spend the money needed to solve the accessibility problem but fail to deal with affordability and other problems, it seems to me that we really haven't addressed the Nation's health care problems. Would you agree with this statement?

Mr. TAYLOR. Yes. I guess politics is the art of the possible, and dealing with the health care problem means taking on a lot of tough battles with the interests involved. It is easier to say, we are in favor of universal coverage, until, of course, you have to come and pay for it.

Mr. PAYNE. Accessibility and affordability is a twofold problem which we need to deal equally with.

Mr. TAYLOR. Yes, and I would argue that even though we spend a great deal more money on health care, if quality includes the total provision of health care to all of the citizens for things they really need, that we do not have the best health care system in terms of quality, it is true that most of us in this room can get access to a lot of very high-tech care—probably too much, on occasion—but that is different from providing the care which ordinary people need and many people don't get.

And you are right to mention, Congressman, that the numbers of people who are afraid of losing their insurance and/or who are afraid or who are upset by the high level of out-of-pocket costs that are high and growing.

Mr. PAYNE. Thank you very much.

The CHAIRMAN. Mr. Spratt.

Mr. SPRATT. I was interested in the graph on your last page. You show a correlation between the way corporate executives and Members of Congress appear to think about this problem; 35 percent of CEOs favor the present system with two changes and 35 percent of Federal legislators do also.

Can you draw any causal connection between those two?

Mr. TAYLOR. No, but it is a happy coincidence.

Mr. SPRATT. I was jesting a little bit, but I was interested to see the 35 percent so low.

What is the makeup of your sample there? Are those larger corporate leaders, or does that run the spectrum of business?

Mr. TAYLOR. It is interesting. We actually have a breakdown in the full report, which is available, by size of company, and it runs

the gamut from very large companies to small companies. The large companies are much more supportive of a pay-or-play, a mandatory-provider option, because they already pay for it and it's not unreasonable to think that others should.

The smaller the company, the greater the likelihood they do not provide it, and the more hostile they are to that proposal.

Mr. PAYNE. Have you seen that percentage grow over time?

Mr. TAYLOR. Yes, over time, the numbers of business people who believe major reform is necessary of any kind has increased. Satisfaction with the status quo has greatly diminished.

But as you see, there is not much appetite for that, and there are two reasons for that. One is that there is still a strongly ideological perception that we don't want Government in Washington running more than it has to; and on the other hand, there are some companies that—which have very expensive health care benefits, a lot of retirees who would actually be only too pleased to shift that to some kind of common pool.

Mr. SPRATT. Who are Federal regulators?

Mr. TAYLOR. Key people in HCFA and some other Government agencies in key positions relative to health care policy.

Mr. SPRATT. Is that a good sample of the makeup of Federal regulators?

Mr. TAYLOR. These are all senior people, yes.

Mr. SPRATT. Below the subcabinet level? Can we say that 60 percent of the Bush Administration connected with health care support mandated benefits?

Mr. TAYLOR. No. I think that would be pushing it.

Mr. SPRATT. Who are they, appointees?

Mr. TAYLOR. They are a mixture of both appointees and career people.

Mr. SPRATT. That is a significant percentage.

Mr. TAYLOR. Yes.

Mr. SPRATT. Thank you very much for your testimony. It was excellent.

The CHAIRMAN. Thank you. After the 5-minute vote, we will return and complete the last panel, if we could. Thank you.

AFTER RECESS

The CHAIRMAN. We will be back in session to hear the last panel which will be Dr. Joshua M. Wiener, Senior Fellow at The Brookings Institution; Peter Sybinsky, Deputy Director for Health Resources, Hawaii Department of Health; Dr. Roger C. Herdman, Assistant Director, Office of Technology Assessment; and Ms. Elaine J. Power, Project Director for Evaluation of the Oregon Medicaid Proposal, Office of Technology Assessment.

Thank you for sticking around. We really appreciate it.

Actually, we could solve the health care problem in this country just by having 300 votes every day so you had to walk back and forth to the Capitol to keep in shape.

Rather than prolong the pain here of bouncing around, I will ask you if you can try to summarize your remarks as best you can and we will try to get you away.

We are interested in the views you present. We will include your statement in the record and ask you to summarize or read it as you wish.

STATEMENT OF JOSHUA M. WIENER, SENIOR FELLOW, THE BROOKINGS INSTITUTION

Mr. WIENER. Mr. Chairman, there is good news and bad news on the issue of long-term care benefits. The bad news is that the United States does not have, either in the private or public sectors, satisfactory mechanisms for helping people anticipate and pay for long-term care. The disabled elderly and their families find, often to their surprise, that neither private insurance nor Medicare covers the costs of long-term care to any significant extent. Instead, the disabled elderly and nonelderly must rely on their own resources or, when these have been exhausted, turn to welfare.

The good news in long-term care financing is that a lot of attention is being given to various financing options. One potential option is private insurance.

Private insurance is a relatively recent phenomenon. The market has been expanding rapidly but only 3 percent of the elderly currently have policies. Studies we and others have done strongly suggest while private long-term care insurance can do more than it is doing now, it is unlikely to substantially change the way long-term care is financed.

This is true for two reasons. First, it is too expensive. Even with a lot of restrictions, the average cost of the better policies is $1,400 a year at age 65 and if you do not buy until age 79, then you are talking about $4,200 a year.

The other problem is that there are enormous uncertainties in pricing private long-term care insurance. This makes it a risky product. Companies have been very cautious in who they will sell policies to and may ultimately limit the number of policies they sell.

The second option is Medicaid reform. The basic argument for staying with Medicaid is it is not the worst of all possible worlds. It meets the most urgent needs at the lowest possible cost. The basic problems with this approach are twofold.

First, it perpetuates a two-class system with inferior status, access, and perhaps care for Medicaid patients. Second, if we think about it, it is a bizarre approach to welfare. Most people who enter nursing homes end up on Medicaid. When we think about other U.S. welfare programs—AFDC, SSI—we expect only a small minority of the population to financially qualify.

The third basic option is social insurance, adding long-term care to Medicare. Under such a program, everyone would pay into a social insurance program and earn the right to benefits without having to prove impoverishment.

There are three advantages and one big disadvantage to this approach. The advantages are universal coverage and the ability to spread the cost over the widest possible revenue base, thus reducing the financial burden on any one individual. If we are smart about it, it can be financed so upper-income people pay more than lower income people.

The basic disadvantage is that all of the proposals cost a lot of money. Even the relatively modest social insurance proposals of the Pepper Commission required $30 billion in new spending. There are no nickels and dimes in the public insurance proposals.

Everyone that really wants to change the way we finance and deliver long-term care is, I think, driven to social insurance. Nonetheless, it still is possible to argue that the benefits of such a program would not be worth the cost. Let me review some of those arguments.

The first is that public long-term care insurance is generationally inequitable. The proponents of generational equity contend it is unfair to have yet another program that benefits the elderly and is financed mostly by the nonelderly. There are three responses to this: The first is that most proposals include nonelderly as well as elderly. Although stability rates are much higher for the elderly, close to half of the community based disabled are under the age of 65.

Second, because the family carries the backbone of community based long-term care, arguably the real beneficiaries in any public long-term care insurance program are the middle-aged caregivers.

Third, generational equity concerns are based on narrow cross-sectional perspective that assumes that, like Peter Pan, the young will never get old.

The second argument is that it costs too much. As I already stated, it is true that a public insurance program will be expensive. However, most of the costs of a program will be incurred by society with or without a program and will surely be incurred if there was widespread purchase of private insurance. Society cannot escape these costs. Thus, the real question is whether the costs will be borne largely by the relative few who need expensive nursing home or home care or whether it will be spread more broadly over society as a whole.

The third argument is that it will cause a tax revolt. Clearly, Americans do not like to pay taxes. There are, however, a long list of things that public opinion polls indicate people would be willing to pay additional taxes to support, including long-term care, education, drug abuse treatment, and protecting the environment. The key is Americans want to see where their money is going.

The fourth objection is that health care for the uninsured is more important. I would agree. It is a scandal that we have 38 million people who are uninsured. The political problem is that public opinion polls consistently show people more willing to pay taxes for public long-term care insurance than they are to address the problems of health care for the uninsured.

The logic of these positions is explained by reference to the basic American principle: What is in it for me? Because the vast majority of Americans have acute care health insurance, to most people it is someone else's problem. Conversely, almost no one has long-term care insurance; thus, in this instance we are clearly talking about a new benefit.

Frankly, in the current environment, neither issue is likely to get very far without the other. Health care for the uninsured needs the willingness to pay taxes of public long-term care insurance and

long-term care needs health care for the uninsured to take the edge off generational equity arguments.

The fifth objection is that public insurance will provide benefits to the upper-income elderly. This is true of all social insurance, but the extent to which that occurs has been overstated. Eighty-five-year-old disabled widows are not the high-income population by and large. Indeed, the fact that Medicare and Social Security benefit everyone is the key to its strong social support. But this point, nonetheless, makes it clear that it is important to finance any long-term care benefit on a progressive basis so that, on net, there will not be a redistribution of income from low-income people to upper-income elderly.

Let me just briefly touch on two program design issues. If at least part of long-term care is to be financed through a social insurance program, many questions remain on how the program should be designed and administered.

One issue is State involvement. Currently, long-term care is primarily the province of the States rather than the Federal Government. All of the major proposals establish limited roles for the States. All of these proposals depend upon States for administration, but exclude them from policymakers and financing. In my view, this is a mistake.

As a former State official, I can assure you that unless the States full financial partners, any public long-term care insurance program will become a Federal funds maximization project, States will seek to get as many people into as many services as possible.

The other issue has to do with expenditure controls. Efforts to pass a public long-term care insurance program have been stymied by concerns about expenditures. There are two parts to this. The first is the absolute level of expenditures. The other is the uncertainty over the estimates of what the costs actually will be. Policymakers are terrified of waking up one day and finding out that the costs are significantly more than originally estimated.

Now, there are a variety of things that can be done to control costs. While I think these mechanisms would work, I cannot guarantee it. To get over the high anxiety, it may be necessary to set an explicit cap on total long-term care expenditures.

Now, I don't offer this proposal lightly since I spent much of my professional career fighting block grants. There is a real possibility that once capped, expenditures will not increase with need.

In conclusion, what should be done? It seems to me we need to move on all three fronts. We need to expand private insurance; we need Medicaid reform; and we need social insurance. In general, I think the strategies set forth by the Pepper Commission make a lot of pragmatic and political sense.

The issue of long-term care is likely to increase substantially over the next 10 years. For one thing, the 75-year-old and older population will increase by 25 percent over that 10-year period. What is even more important is that over the next 10 years, all of the parents of the baby boom generation will be elderly and have to face long-term care. As a result, their baby boomer children will have to face long-term care, not as an abstraction, but as an intensely personal issue. How are we going to take care of mom is going to be on the minds of an entire generation.

Once that happens it is going to become a political issue that neither the President nor the Congress can ignore. Thank you.

[The prepared statement of Mr. Wiener may be found at end of hearing.]

The CHAIRMAN. Thank you. Dr. Sybinsky.

STATEMENT OF PETER SYBINSKY, Ph.D., DEPUTY DIRECTOR FOR HEALTH RESOURCES, HAWAII DEPARTMENT OF HEALTH

Dr. SYBINSKY. Mr. Chairman, Members, I bring you the greetings of our Governor, Governor John Waihee. He is very interested in health care reform and looks forward to contributing to a national solution to this problem.

As the Deputy Director of Health of the State of Hawaii, I represent Dr. John Lewin, who is the Director of Health and unable to attend today.

Dr. Lewin is also President of the Association of State and Territorial Health Officers (ASTHO) and as such has made access issues and the very problems that this Committee is addressing in this hearing the highest priority of ASTHO for this year.

I have a very long and involved testimony which I will do my best to summarize; but needless to say, we would welcome your Committee coming out to Hawaii to investigate this issue more thoroughly if I do not do a good job.

The CHAIRMAN. As of today, we could try to do it tomorrow.

Dr. SYBINSKY. Let me start off by exploring a few basics about the current structures in Hawaii's system.

The Prepaid Health Care Act was adopted in 1974 to provide health insurance and medical protection insurance for most employees in the State. The measure was passed in a time of moderate unemployment in an environment of already strong employment-based health care coverage. Effects on unemployment have been negligible and, in fact, over the last 16 years, our unemployment rate has fallen to the lowest in the Nation.

I make no claims about a cause/effect relationship in this regard, but this does seem to modify assertions that such mandates would cause unemployment.

The Prepaid Health Care law is the first and only State-mandated benefits plan in the Nation. Virtually all employees are required to provide health insurance to their employees. Dependent coverage is optional. Costs are shared in this program. The employee pays up to 1.5 percent of monthly wages up to half the premium cost. The employer provides the balance.

Employers may provide benefits as outlined in the act on a self-insured basis but are still subject to the requirements that those services be provided. Two basic plans are available, a fee-for-service plan and a health maintenance plan. The fee-for-service plan is the plan most used in Hawaii, and provides for a good package of diagnostic and treatment services with copayments and deductibles. The HMO provides a generous package of benefits; these benefits are outlined in the attached administrative rules.

Exclusions. Some of those excluded from the provisions of the act are Government employees—who have their own plan—seasonal agricultural workers, real estate and insurance agents working on

commission, individual proprietorship members in small family business, and Government assistance program recipients.

No large State bureaucracy has been created to administer the provisions.

An employer fund exists to assist employers who cannot because of economic limitations, provide for the cost of the insurance and to assist employees whose employers have gone out of business or who have not provided for the insurance.

I want to emphasize the next couple of sentences. By requiring virtually all employers to provide insurance, Prepaid Health Care has permitted health care insurers to provide health insurance rates for small employers which are comparable to those enjoyed by large employers.

This has happened because we have a community rating system in Hawaii. Adverse risks are thus a part of an overall pool which eliminates the need for insurance companies to individually rate employers.

Community rating is voluntary. It is not required as part of the law, but the general mode of operation for the major insurers in Hawaii since before Prepaid Health Care.

The results have been extremely positive. Small business can purchase insurance at reasonable rates and these rates are exceptionally low even though our people, of course, would call them high. There are at least 50 percent lower than comparable Blue Cross rates elsewhere in the Nation.

Insurance companies cut administrative costs and market to a large pool of businesses. Employees, of course, are covered with health insurance.

Prepaid Health Care has provided a uniformly level field for competition in which responsible businesses who provide insurance are not at a competitive disadvantage relative to those who do not.

The effects of Prepaid Health Care is evident. In 1971, Hawaii had 17 percent of its population in the gap group and was similar in this regard to California and East Coast States.

The implementation of Prepaid Health Care brought about a dramatic drop in the figures as per several surveys that had been conducted afterward. Estimates of those enfranchised with health insurance range from a low of 3,000 people to over 46,000 people and significant additional numbers of workers have had better benefit coverage as a result of this program.

The Department of Health has estimated that the uninsured population in Hawaii as of several years ago was approximately 5 percent as a basis before we started our additional modifications of our system. Populations still exist in Hawaii that are in the gap group. These are made up largely of the unemployed, dependents of low income workers, especially children, part-time workers, seasonal workers, and other people who because of their location or various lifestyle factors also fit into this area.

To respond to these gap group people, particularly those at risk of not being able to purchase insurance because of income, the State has made two major efforts. The first is that it has adopted most of the options that were offered by the Congress before they became mandates. These have significantly added to the people

who have been covered with health care benefits and have helped to cut the rate below 5 percent.

The second element has been the implementation of the State health insurance program or SHIP. SHIP was created to meet the needs of the gap group and provide access to universal health care coverage for all in Hawaii. Through SHIP, Government subsidizes insurance coverage for those unable to pay.

Insurance companies provide the coverage and the already existing health care providers deliver direct care. This is essentially very similar to the model adopted by the State of Washington in its pathbreaking Basic Health program. We do owe a lot of credit to the State of Washington because we do work closely with them. They taught us a lot about how to run a public insurance program.

Benefits of SHIP are heavily weighted toward preventive and primary care. Instead of putting our money at the end of the spectrum where catastrophic care is and gets most attention, we try to tailor this program to the population we were directing it at, the low income, uninsured which we are finding, and the State of Washington found, are basically healthy people, young people, and employed people. So we are providing preventive and primary care, the very things this population needs so badly.

The costs of our insurance are very low to those people in need. The Table A that we have shows the monthly fee schedule which was adopted for the program. Under 100 percent poverty, people pay nothing, except a modest copayment at the time of service. Above 100 percent of poverty, the copayment rises, the monthly charge rises until at 300 percent of poverty, people are paying the cost of the insurance.

SHIP is delivered through contracts with the State's largest insurance companies, the two large insurance companies, HMSA, which is a Blue Cross-Blue Shield and Kaiser Permanente, which covers health maintenance contracts with us.

I do not want to go into detail on the implementation. There are several pages on that. It has been very exciting. We have tried to be nontraditional in these programs, to limit bureaucratic barriers and truly go out and get people who might not be reached by Government programs. This has meant publicity, a grassroots effort to enroll people in insurance, and taught us that those kinds of things have to be done if we are to reach a lot of the people who are uninsured.

As a result of our efforts, we have insured over 10,000 members and have provided services to more. Some people have been dropping off to get employment. Some people have dropped off to get into Medicaid. As a result, we have serviced over 12,000 people in this year our program has been on track.

SHIP members are in general young. Forty-six percent of our people are under age 18. Our outreach has been successful because most—about 50 percent— of our people are from rural areas and neighbor islands. Sixty-one percent of our people have income below the Federal poverty level. We are going to be looking at this population to see how we can better dovetail our efforts with those of Medicaid.

Ninety-five percent of SHIP's population is below the 200 percent of poverty level. There is not too much interest in our program be-

tween 200 and 300 percent of poverty, even though it is open to the people who are better off.

These results to an extent mirror what other States such as Washington are finding out in their programs, that—as I mentioned before, the uninsured are good insurance risks and if we can provide them with a good insurance program, we will really be meeting a national need.

As for our own specific recommendations, Hawaii envisions implementing the Nation's first seamless universal health care system as a national demonstration project. Some of our ideas have been listed here. We intend to very thoroughly work with the health care industry and business, labor, and our community to further develop these proposals.

I am not going to elaborate on them here. What we want to do is build on present strengths, correct weaknesses, and increase efficiency while addressing the concern that was reflected this morning about the importance of addressing costs. That is a major focus we have to deal with.

We also have to bring in long-term care and make sure that that is related in one way or the other to our total efforts and it is not going off in a different direction.

Our effort would be a private sector effort of managed competition, promoting incentives, consumer choice, maintaining the private practice model, but better integrating the health services that are provided by the medical sector.

Certainly, I emphasize, we do want to keep private insurance and emphasize very heavily the need for primary care availability to all people.

As a State, we are proud to be able to contribute what we can to this Committee. Rather than attempting to create a national health insurance or a national health delivery system, we strongly recommend that the States be heavily involved in this effort and that State efforts can—are already happening and can help solve the problem of covering the uninsured.

Some of our recommendations would alter current Federal policies or programs, which inhibit State capacity for experimentation. I want to emphasize again, we did experimentation. We know it can work and can help serve as a model to the other States and to the national Government.

We propose that that flexibility in areas such as ERISA, Medicaid, and perhaps other insurance legislation be given to the States, and that we keep in mind the words of Justice Brandeis, when he said:

> The State experimentation on things social and economic is a great responsibility. Denial of the experiment may be fraught with serious consequences to the Nation. It is one of the happy instances of the Federal system that a single courageous State may, if its citizens choose, serve as a laboratory to try noble social and economic experiment without risk to the rest of the country.

We do want to work on that effort. Thank you very much for the opportunity, Mr. Chairman.

[The prepared statement of Dr. Lewin, presented by Dr. Sybinsky, may be found at end of hearing.]

The CHAIRMAN. Thank you. I think we are about 4 minutes or 5 minutes away from finalizing this vote. We have to go.

Dr. Herdman, Ms. Power, please say a little longer. We will be right back after this vote.

AFTER RECESS

The CHAIRMAN. The Committee is back in session for purposes of, hopefully, concluding this panel.

Dr. Herdman, you may proceed.

STATEMENTS OF ROGER C. HERDMAN, M.D., ASSISTANT DIRECTOR, OFFICE OF TECHNOLOGY ASSESSMENT AND ELAINE J. POWER, PROJECT DIRECTOR FOR EVALUATION OF THE OREGON MEDICAID PROPOSAL, OFFICE OF TECHNOLOGY ASSESSMENT

Dr. HERDMAN. Thank you, Mr. Chairman. Ms. Power will be giving OTA's testimony.

Ms. POWER. I am Elaine Power, Project Director of OTA's assessment of the Oregon Medicaid proposal. Dr. Herdman is OTA's Assistant Director for Health and Life Sciences.

The State of Oregon has estimate that as many as 450,000 people in the State have no health insurance. In 1989, the Oregon State Legislature passed the Oregon Basic Health Services Act, which consists of three bills to expand access to health insurance in the State. Each of the three bills targets a specific segment of the uninsured population. Senate Bill 27 expands the Oregon Medicaid program to include all persons with incomes up to the Federal poverty level. SB 534 establishes a State high-risk insurance pool for persons whose incomes are above the poverty level, but who are unable to purchase insurance due to preexisting health conditions. SB 935 encourages, and ultimately requires that small businesses provide their employees with health insurance that covers at least the level of services covered for the Medicaid population under SB 27.

I will focus the rest of my remarks on SB 27, which makes major changes to almost every aspect of the State's Medicaid program.

First of all, it expands the Medicaid-eligible population to include all State residents with incomes below the Federal poverty level. In contrast, at present, most people in Oregon must have incomes that are less than 70 percent of the Federal poverty level to qualify for Medicaid. Oregon has estimated that this provision will eventually add about 120,000 people to the Medicaid rolls.

Reimbursement for Medicaid services and the system for delivering those services will also change under SB 27. Most Medicaid recipients will be enrolled in mandatory managed care, with reimbursement on a prepaid per capita basis. Certain residents of rural counties are exempted from this requirement, and they will continue under fee-for-services rules. Reimbursement to providers, in general, is supposed to be increased to encourage provers to participate in the program.

Finally, the package of covered services to which Medicaid recipients are entitled could change substantially. For those Medicaid recipients subject to SB 27, the covered services will be determined

by a prioritized list of health services in which health conditions and their treatments are listed in importance from highest to lowest. The State legislature takes this list, determines its budget, and then draws a line on the list at the point where the predicted cost of providing services is equal to the budget. Conditions and their associated treatments above the line are covered; those below the line are not covered. Diagnostic services needed to identify a condition will be covered regardless of whether the treatment falls below the line.

Oregon has a 2-year budget cycle. An important provision of the plan is that if there is a funding shortfall during that time, the program will reduce services rather than cut people from the program or lower provider payments. If necessary, services would be eliminated in reverse order of importance, based on the list.

The new service package does not apply to current elderly and disabled Medicaid recipients. These groups are not affected by SB 27 and will get the same services under the same rules as before. Long-term care services are not included on the prioritized list. Mental health services are presently excluded from the list as well, although they are scheduled to be phased in in the future.

The list itself was developed by a Commission established in law for that purpose. To derive the list, the Commission first assigned all relevant medical diagnoses and procedures into 709 condition-treatment pairs. For example, end-stage renal disease, as the condition, and kidney transplant, one of the treatments for that condition, are a condition-treatment pair. Birth trauma and medical therapy are another example of a condition-treatment pair.

The Commission then used provider and public input and their own judgment to assign each condition-treatment pair to a general category of service, such as maternity care or comfort care. They then ranked the general categories, and then within each category they ranked the condition-treatment pairs. Finally, they moved individual condition-treatment pairs around the list, both within and across categories, where they thought it appropriate.

The Commission submitted the final list to the Oregon legislature on May 1, and the legislature is currently debating where exactly the line is to be. After the package of covered services is determined, based on this line, the State will submit its waiver application to the Federal Government.

OTA's study of the Oregon proposal is assessing both the list itself, and the process used to establish it, and the broader implications to beneficiaries and providers of implementing the overall Medicaid proposal, with all of its different components. The report from this study is scheduled to be delivered to Congress this winter. The General Accounting Office has a related study examining Oregon's Medicaid managed-care program, and we are coordinating with them.

Thank you, Mr. Chairman, and I would be happy to answer any questions you have.

[The prepared statement of Dr. Herdman and Ms. Power may be found at end of hearing.]

The CHAIRMAN. Thank you very much. Again, thanks to all of you for your patience in sticking around and giving us the benefit of your thoughts.

Can I ask you, Ms. Power, what are the problems you are running into with regard to trying to establish these required levels of treatment?

Ms. POWER. We are examining what Oregon did when they tried to establish the condition-treatment pairs. We are in the middle of a study. We do not have conclusions about necessarily the problems they ran into. We have been trying to understand the process by which they came up with it, which is fairly complicated.

The CHAIRMAN. I would think that the paperwork associated with something like this has to be horrendous.

Ms. POWER. I don't know what they budgeted for their administrative costs. I am sure they must have something set aside for that.

The CHAIRMAN. Well, is their approach to only implement this if they run into cost problems in the 2-year cycle? Is this something they will be implementing under any circumstances?

Ms. POWER. What they have said is, if they can get a waiver from the Federal Government to permit them to put it in place, that it would be implemented, I believe, in 1993. They plan to go forward with it.

Then the only question is, once it was implemented, whether or not they would have to reduce services if they had a funding shortfall within their budget cycle. I believe they intend to implement it if they get the Federal waiver.

The CHAIRMAN. Well, I guess the question I have is, If a person has an end-stage renal disease and kidney transplant is one treatment for that condition, are you basically then saying that in this instance where you have this level of disease, we are going to limit it to this one treatment?

Ms. POWER. It really is hard without looking at the list.

What they have done in this case is, end-stage renal disease falls in more than one place. For example, dialysis would be a different one. It is in a different place on the list.

At the moment, the kind of place the line might be drawn on the list might result in both of those alternative treatments ending up above the line. The physicians would have the choice of providing the kidney transplant or dialysis.

The CHAIRMAN. Does age play any role in it?

Ms. POWER. The way it is set right now in the current list, it does not make a difference in whether or not it would be covered.

Dr. HERDMAN. I want to be sure you understand the answer, Mr. Chairman.

The list is broadly divided into three categories, essential, very important, and valuable to some.

The CHAIRMAN. I see.

Dr. HERDMAN. Where the line is drawn, some condition-treatment pairs, which are described—if we can accept that description—as valuable to some, will not be funded; that is, patients in Oregon who have that condition and need any one of those treatments appropriate for that condition will not receive it, or at least will not have it financed by the Medicaid program in that State.

The CHAIRMAN. I would imagine that just like Members of Congress, you get very different views on what some might consider, you know, some importance versus what others might consider critical. I am not sure how you get that kind of consensus in Oregon. It would be interesting if you can do it.

May I ask, on Hawaii, you essentially have a mandated-benefits approach in Hawaii; is that not the case?

Dr. SYBINSKY. That is correct, Mr. Chairman.

The CHAIRMAN. How long has that been in operation in Hawaii?

Dr. SYBINSKY. Seventeen years. We started in 1974.

The CHAIRMAN. May I ask you what the level of satisfaction is with regard to your health care system in Hawaii?

Dr. SYBINSKY. I think people are generally satisfied.

We have not done the kind of satisfaction studies outlined by Lou Harris. We certainly welcome any work in that area, because it is important that people be as satisfied with the system as possible.

The CHAIRMAN. Your impression is that most Hawaiians are satisfied with their health care system?

Dr. SYBINSKY. I think so. I think we do have high-quality care, very up-to-date.

The CHAIRMAN. The argument of the small businessman, was that a problem there in terms of mandating?

Dr. SYBINSKY. It certainly was. Of course, the Chamber of Commerce and other small business organizations, did oppose the Prepaid Health Care Act when it was put together. But I think part of it is a lack of putting their situation in perspective.

The amount they pay for health insurance for their employees, as I mentioned, if you compare it to someone in Arizona, or New York, or California, it is much, much lower. Of course, they see the problem in their own community, and they are going to be dissatisfied with the cost of health insurance. Most small business people do not like any Government regulation at all.

I think they are generally satisfied with the care. Businessmen will complain about the law, but I don't think they are so dissatisfied they would overturn it.

The CHAIRMAN. Dr. Wiener, if you were given power of the Congress and the President for 1 day to decide these issues, what would be your approach to dealing with health care? Would it be incremental? Would it be single-payer? What kind of approach would you recommend?

Mr. WIENER. I think I would take a different strategy for acute care and for long-term care.

On acute care, I think what we ought to have some sort of employer-mandated benefits combined with single-payer rate setting and budget setting, something along the lines of what Henry Aaron has outlined in his book that is coming out next week.

In terms of long-term care, it seems we have a different situation. We have no tradition of private insurance there. We have a welfare system and out-of-pocket payments. There, I think we need a combination of things, but I think what the Pepper Commission proposed makes a lot of political and pragmatic sense. What they proposed was making home care and front-end nursing home care be covered under social insurance, liberalizing the Medicaid pro-

gram, and having a substantial role for private insurance to cover back-end—that is, long-stay nursing home coverage.

It seems to me that makes sense and has a nice balance among the three options.

The CHAIRMAN. So your general approach would be—I don't want to describe it as incremental. You would basically work with the existing system in terms of improvements as it is currently shaped as opposed to something more dramatic?

Mr. WIENER. In terms of acute care, you only gave me President for the day. If you gave me God for the day, I would probably move to a national health insurance system.

It seems to me that national health insurance solves a lot of the problems and allows certain kinds of power to make the system do what you want and allows at least some of the administrative savings that GAO and others have been talking about in terms of the Canadian health care system.

The CHAIRMAN. Have you looked at the Canadian health care system?

Mr. WIENER. I have to a certain extent. As Lou Harris and others have indicated, they find substantial degree of satisfaction. They have everyone insured.

I think the bottom line, though, is that they do only somewhat better than we do in terms of their overall rate of increase in health care expenditures.

What I found in looking at other countries in terms of their health care costs is that they vary dramatically in terms of their health care costs. Great Britain has about a quarter of the health care costs that the United States has on a per capita basis, but there is not really very much difference in the rate of increase across countries between the United States and Great Britain.

The CHAIRMAN. Mr. Spratt.

Mr. SPRATT. How did Oregon implement the system? Did they have a waiver from Medicaid?

Ms. POWER. They haven't got it yet. They plan to submit one later this summer or early this fall. They will have to wait until they see what happens to that.

Mr. SPRATT. This implementation is contingent on a waiver from Medicaid?

Ms. POWER. Right.

Mr. SPRATT. On the lower tier of their priorities, valuable to some, what sort of treatments, maladies and treatments are listed?

Ms. POWER. Infertility treatment, for example, is one of the things fairly low on the list.

Mr. SPRATT. Transplants fall below that line?

Ms. POWER. Transplants are sprinkled all over the list. There are a few that are quite high. There are a couple quite low, in the high 600s. A lot around the middle of the list.

It depends on which condition needs the transplant. Bone marrow transplants appear all over the place. Quite a few are on the high end. Whether or not you get the bone marrow transplant depends upon where the line is drawn and which condition you have, whether that condition-treatment is above or below.

Mr. SPRATT. Heart bypass operations, where would they fall?

Ms. POWER. I can't recall where that is. I could let you know.

Mr. SPRATT. It seems to me the one problem with providing universal coverage and at the same time controlling costs is that the demand will increase for medical services, will increase substantially if the 35 to 40 million people who have no or inadequate coverage today are provided some reasonable level of coverage.

I know many of them are finding treatment through one means or the other, showing up in the emergency room, the outpatient clinics. But none of you have talked about coupling this kind of payment reform with capital cost controls or other cost controls.

Do you think there has to be a coupling in order to contain the increased demand that universal coverage would generate?

Mr. WIENER. Let me respond to part of that. First of all, I think it is important to keep in mind how much you are actually talking about. In general, the uninsured get between onnne-half and two-thirds of the health care services of the insured. So with 15 percent of the population uninsured, we are talking about adding 5 percent to the national health budget, if we can't find any other savings anywhere else in the system.

I find it hard to believe we could not find 5 percent of health care savings somewhere in the system. But I think there is no doubt that you are right, that insurance is at least one of the culprits in terms of increasing health care costs.

The more people you make insured, the more you add to those inflationary pressures. That is why I think we need to go to some kind of single payor system, and capital controls are clearly part of it. A lot of our costs are generated by those MRIs, other machines, that they buy and then we just spin out the costs from it.

Dr. HERDMAN. I could add that although OTA has not looked at this issue, we are aware of the literature which says that past payment systems, to some extent current payment systems and do encourage capital expenditures by virtue of—at least in the past, passthroughs, guaranteed profits, return on equity, and so on, and that the United States does have—the best word escapes me—certainly a splendid capital plant with its health care.

Dr. SYBINSKY. I would like to add to the discussion that we have come closest to any State and we do have, I think, probably the lowest per capita cost for insurance in the nation, comparably speaking.

Mr. SPRATT. What has been your rate of increase since you provided the mandated universal coverage?

Dr. SYBINSKY. We do not have figures to compare before and after. Our rate of increase is significant and very worrisome to us.

As people mentioned this morning, we do have to get a handle on the costs. But one of the tributes that we think can really reduce costs are dealing with primary and preventive care up front, making sure those services are available. Those kinds of things might be the sort of thing you might not want to put a deductible on.

Specialist care, other more technical and expensive procedures may well be assisted with some copayments, but if you get the primary and preventive care up front, you will have a healthier population and reduce the back-end costs of catastrophic are.

Similarly, if you manage the economics of the system such as the physician referral, using case managers and other forms of cost

controls, we can actually provide better care at reduced costs. That is another factor that we would like to look into.

Mr. SPRATT. None of you mentioned—primarily because of what you were talking about, but none of you took up the topic of defensive medicine, what it is costing us in terms of the total amount we spend.

Nobody that has testified whom I have heard today has mentioned the PROs. I spent a fair amount of my time listening to doctors and hospital administrators complain about Medicare. This is one of their principal complaints.

In my State, at least, they are firmly of the opinion that the PROs today generate more defensive medicine than the malpractice threat. In South Carolina we do have an enormous malpractice threat. It is not as serious as it is in some States that are more litigation prone, but the PROs are an increasing bone of contention with the doctors.

Having listened to their cases, I sat through one of the second largest hospitals in my district a couple of weeks ago. One doctor who won the prize for the best anecdote said literally on the same day he received two letters from his PRO. One was a letter reprimanded him for unnecessarily admitting a patient and denying payment for that particular admission. A separate letter came as to the same patient as it turned out reprimanding him for prematurely discharging the same patient.

All of them had indications that were more than just capping. They all said that clearly they were ordering more CAT scans, doing more diagnostic tests to make sure they didn't get second guessed by the PRO review.

Do you have any observations about that yourselves? Does that fall outside the purview of what you have been doing?

Dr. HERDMAN. Well, I don't think we have any observations right now, Congressman.

I would say that it is clear, and Members of Congress have made it explicit to us, that defensive medicine is a substantial problem, one that deserves further study.

It is my view that OTA may well be embarking on such a study in the very near future. I say "may" because I am not in a position to comment on studies before they are approved by our board. As you know, we have to consult with people before we take on a study and begin. I am confident that we may well be.

If you or the Committee has an interest in such a study and would like to request that or endorse it, we would be very happy to hear from you.

Mr. SPRATT. I will be delighted to do it. I will send a copy to the doctors I met with last Monday night.

Mr. WIENER. I don't have any specific information about PROs. I think it is important to remember where they came from. They came from a concern that a substantial amount of health care was either inappropriately applied or unnecessarily applied.

One can only look at the vast differences across geographic areas in terms of utilization rates, in terms of hospital lengths of stay, without scratching your head and wondering whether all of it is necessary. There is now a large, extremely controversial literature that suggests that substantial portions of a variety of procedures

such as coronary artery bypass surgery is questionable, if not unnecessary.

So long as the Congress is concerned about the public purse and as this Committee always has been and always will be, I think the PROs out there trying to make sure——

Mr. SPRATT. In South Carolina, the PROs have ceased giving prospective opinions. They have just announced they found it simply not worth the effort; it is not yielding that cases of unnecessary treatment. So they are going to confine themselves solely to retrospective reviews.

Mr. WIENER. It is always easier to do a retrospective review because the case is closed.

Mr. SPRATT. Thank you very much.

The CHAIRMAN. On the Oregon situation, have you seen what the political situation is like? Are they running into trouble trying to ration health care services there?

Ms. POWER. Well, the current state, as we understand it, as of a couple of days ago, on their proposal to draw the line on their list of services was that the legislative subcommittee that had the initial recommendation to make had recommended drawing the line around 533 out of 790. That is only about two-thirds of the way down the list.

But apparently also recommended on that they hoped that somebody would come up with more money so they could draw the line further down. We are waiting to see what happens. Obviously, a lot of what people think of it and what the implications of it are depends on whether they draw the line in the middle or almost at the bottom.

The CHAIRMAN. It ought to be fascinating to see. It is like the other issues you discuss here. Everybody sees a nice, simple answer until you start to get into it. Then people see the other side of it. All hell breaks loose.

I have a feeling they may run into a buzz saw with this thing. It will be interesting to follow.

Again, thanks to all of you for your testimony. We are neither God nor the President nor, for that matter, the Congress. One thing is clear. We have walked into a cauldron of doing something about health care and I have a sense that if it does not happen in this session of the Congress, it will before the end of the 1990's, that there will be action taken on the health care delivery system. I guess the only hope is we take the right approach.

I have a feeling as George Mitchell said today, that in every solution there are seeds of additional problems. I have a feeling we will walk right into that.

It is pretty clear both the country as well as from a budget point of view, that we have no alternative but to confront this issue. It will represent 20 percent of the Federal budget. You combine that with interest payments. You are talking about almost 50 percent of the Federal budget being represented by just two areas. There is no alternative but to confront these issues. Thank you for your testimony.

[Additional material submitted for the record follows:]

PREPARED STATEMENT OF HON. HENRY A. WAXMAN

Mr. Chairman and Members of the Committee, I am pleased to appear before you this morning to discuss one of the most urgent domestic issues facing this country: health care reform.

Recently, Senator Rockefeller and I introduced legislation to implement the health care reform recommendations of the Pepper Commission. You will be hearing shortly from Senator Mitchell, who recently introduced a comprehensive health care reform bill, as well as our colleague in the House, Mr. Stark, who has his own initiative. My Committee, along with the Ways and Means and Education and Labor Committees, is working with the House Leadership to develop an initiative that House Democrats can support.

The Administration

Only the Bush Administration doesn't seem to see the urgency of the problem. In his State of the Union message just five months ago, President Bush said, "Good health care is every American's right." Unfortunately, there are millions of Americans who, unlike the President -- and Members of Congress -- do not have access to good health care. Yet the Secretary of Health and Human Services has spent the last few months telling audiences around the country just what the Administration is against, which includes all of the reform proposals you will hear about this morning. We still have no clue what -- if anything -- the Administration is for, other than personal responsibility and malpractice reform.

The Pepper Commission

I've been asked to outline the Pepper Commission approach. Attached to my testimony is a short summary of the House version, H.R. 2535, which I introduced earlier this month.

Under this bill, all Americans would have coverage for basic health care -- preventive, hospital, and physician services -- in one of three ways: through their employers; through a new, Federally run public plan; or, in the case of the elderly and disabled, through Medicare.

Large and medium-sized employers would be required to assure that all full-time employees and dependents have coverage for basic health services. Employers could meet this obligation either by offering private coverage or by enrolling their employees in the new public program for a premium set at a fixed percent of payroll.

Unlike an employer "mandate," under which employers would be required to purchase private insurance coverage for their employees and dependents regardless of cost, this "play or pay" approach guarantees employers that their financial exposure is limited to a fixed percent of payroll. At the same time, if the employer premium level is set high enough, the "play or pay" does not create an incentive for most employers to move their employees into the public plan, keeping on-budget costs down.

To control private and public health care spending, my bill does several things.

First, it creates incentives for consumers to be cost-conscious by subjecting all of the basic health services other than preventive care to deductibles of $250 per individual and $500 per family, and by imposing a 20 percent coinsurance obligation. Low-income people would given assistance in meeting these cost-sharing requirements.

Second, the bill gives employers, insurers, labor-management funds, and other private purchasers the option to use public plan rates in paying for hospital, physician, and other basic health care services. The public plan will pay for basic health services using Medicare principles.

Finally, the bill creates incentives for the use of managed care, preempts State minimum benefits laws, and directs the development and use of clinical practice guidelines.

Although the bill will help restrain health care costs, it will still require significant additional Federal funds. I don't yet know exactly how much, but I have requested estimates from both CBO and OMB. Some of these costs would be paid for by the premium contributions made to the public plan by employers who choose to "pay" and by individuals outside the workforce who choose to enroll. My proposal for the rest of the financing needed to keep the public program on a pay-as-you-go basis would be a surtax on individual and corporate income tax liability. The exact amount of the surtax would be set once estimates of the public program costs are available.

I suggest this surtax because it is simple to administer and understand, broad-based, moderately progressive, and is likely to grow over time. I recognize that there are other potential revenue sources that the committees of jurisdiction may wish to use instead. The important point is that the public program be given a revenue source that is stable and avoids the chronic underfinancing that plagues the Medicaid program.

Concluding Observations

In closing, I want to make four points.

First, the way we pay for health care in this country is fundamentally flawed. The system is broken and it needs to be fixed. Leaving things alone won't solve the problem. Instead, costs will continue to climb, and more Americans will become uninsured or underinsured. For millions of Americans, access to basic health care services will be threatened.

Second, the longer we wait to begin to solve this problem, the more expensive the solution will be. Health care costs are projected to grow at least 12% per year over the next few years. At this rate, to assure that all Americans have access to a basic package of services will cost 57% more in 1995 than it would cost today and 147% more in the year 2000 than it would cost today.

Third, even with effective cost controls, health care reform will not be budget neutral. No one disputes that there are substantial savings to be had from eliminating inappropriate care, reducing administrative overhead, and other system reforms. But these savings will not be sufficient to supply all of the additional resources needed to assure that all Americans have coverage for basic health care services. The numbers of uninsured and underinsured Americans is simply too large.

My final point is that if we are serious about giving all Americans coverage for basic health care services, there are really only two roads to reform. One is to build on the existing employment-based health insurance system, as the Pepper Commission bill and Senator Mitchell's proposal would do. The other is to phase out the current private health insurance system and replace it with Medicare, as Mr. Stark's bill would do, or with a new public health insurance program, as Mr. Dingell's bill or Mr. Russo's bill or Ms. Oakar's bill would do.

The road we must avoid is the one which looks to each State to develop its own solution to paying for basic health services. The Medicaid program teaches us that State revenue growth cannot, over time, keep pace with the costs of providing basic health care services, even where drastic cost controls -- such as limiting covered hospital days to 18 per year -- are used. If States are given a major role in financing health care services, they will insist on "flexibility" to control their expenditures by limiting benefits, lowering reimbursement, or reducing eligibility.

I believe that all Americans, whether they live in California or Maine or Texas or Tennessee, should be entitled to coverage for basic health services. I look forward to working with you and the members of this Committee to design and fund a program that will achieve this goal as soon as possible.

Brief Summary of
H.R. 2535
Pepper Commission Health Care Access and Reform Act of 1991
(Waxman)
6/4/91

Overview. At full implementation, all Americans would have coverage for basic health services through one of the following: (1) private group health insurance offered by their employers; (2) a new, Federally-administered public health insurance program; (3) Medicare; or (4) qualified individual health insurance policies. Basic health services would include hospital, physician, diagnostic, preventive, and limited mental health services. With the exception of preventive services, these services would be subject to deductibles and coinsurance requirements, with an overall annual limit on cost-sharing of $3,000 per family. Private purchasers -- employers, unions, health insurers, managed care plans -- would be able to use the same payment rates for basic health services that Medicare and the new public program use. Health insurance products sold to firms with 100 or less employees would be subject to minimum standards designed to make group coverage accessible to employers. Low income persons would be eligible for subsidies that limit or eliminate cost-sharing obligations. Capital funds would be made available to expand primary care and public health delivery capacity. The bill would be financed on a pay-as-you-go basis, with funds for the public health insurance plan coming from a combination of employer and individual premiums and a surtax on personal and corporate income tax liability. These reforms would be phased in over 5 years.

Employer-based Coverage. By full implementation, all employers with 25 or more employees would be required to offer coverage for basic health care services to their full-time employees and dependents on a "play or pay" basis. Employers could meet this requirement by (1) purchasing private group health insurance (or self-insuring), or (2) paying a premium set at a fixed percent of payroll to enroll their employees and dependents in the public health insurance plan. The percent of payroll would be fixed by the Secretary of HHS to assure that employers do not have stronger incentives to enroll their employees in the public health insurance plan than to insure them privately. If the Secretary does not set the percent, the bill would set it at 7. Employers opting to purchase private group insurance coverage would be required to pay at least 80 percent of the premium; low-income employees could qualify for subsidies (paid by the public plan) for their share of premiums and deductibles.

Employers with fewer than 25 (but more than 4) employees would be subject to this "pay or play" requirement only if, by the end of the 4th year after enactment, less than a specified target percentage of their employees have no coverage for basic health services. Employers with fewer than 5 employees would be exempt from this requirement altogether; they and their employees could enroll in the public plan on an individual basis.

Public Health Insurance Plan. Beginning with the third year after enactment, all individuals who are not covered through their employers

(or through an individual qualified health insurance policy) would be eligible to enroll in a public health insurance plan. The plan would offer coverage for the same package of basic health services (including parallel deductible and coinsurance requirements) that employers would be required to offer, plus early and periodic screening, diagnosis, and treatment (EPSDT) services for children. The Secretary would be directed to develop clinical practice guidelines with respect to these services to assure quality. The public plan would be administered by the Federal government using private fiscal agents to process claims. The program would have no ties to Medicaid or the welfare system. Low-income individuals enrolling in the public plan would also be eligible for premium and deductible subsidies related to income.

Medicare. The Medicare program would be left intact. Beneficiaries would be able to obtain Medigap supplemental coverage through the public health insurance plan. Coverage of preventive services would be expanded to include colorectal cancer screening. Low-income beneficiaries would be eligible for assistance with Medicare premiums, deductibles, and cost-sharing requirements under the public plan.

Medicaid. Current Medicaid beneficiaries would receive coverage for basic health services under either the new public health insurance plan or through their employers. Medicaid benefits that are not included in the basic health services package (e.g., prescription drugs, nursing home care) would continue to be offered through the current Medicaid program under existing rules. Current State spending for Medicaid coverage for the basic health services would be phased out entirely by full implementation.

Cost Containment. The basic health services package is subject to deductibles of $250 per individual, $500 per family. The public health insurance plan would pay for basic health services using Medicare payment rules. Private purchasers (health insurers, employers, labor-management funds, etc.) would, at their option, be able to use the public plan's payment rates in purchasing basic health services for their own enrollees. The bill would preempt State laws mandating the coverage of services other than those contained in the basic health services package, as well as State laws restricting the use qualified managed care plans.

Small Group Insurance Reforms. States would be required, by the third year after enactment, to enforce minimum federal standards on all health insurance products marketed to employers. No qualified plan could deny or limit coverage of basic health services to any individual on the basis of health or risk status. The Secretary of HHS, in consultation with the Secretary of Labor, would apply minimum standards to self-insured employment-related plans. If a State failed to establish or maintain an acceptable regulatory program, the Secretary would be authorized to certify all health insurance products marketed to employers in the State. Qualified health plans offered to small employers (100 or fewer employees) would be required to offer at least a basic benefit plan, use community rating, guarantee issue and renewal of policies, and meet certain information disclosure

requirements.

Financing. The costs of the public health insurance plan would be financed from three sources: (1) the premiums (set at a fixed percent of payroll) paid by those employers opting to enroll their employees in the public plan; (2) the premiums (set on a community-rated basis) paid by individuals enrolling in the public plan on a non-employment basis; and (3) the revenues from a surtax on personal and corporate income tax liability. The surtax would be set at a level necessary to generate the revenues needed to fund the public plan costs that are not covered by the employer and individual premiums. Funds from all three sources would be credited to a Public Health Insurance Trust Fund, from which benefits would be paid.

Primary Care and Public Health Delivery Capacity. The Secretary would be directed to spend, each year, between 0.5 and 1.0 percent of the amounts in the Public Health Insurance Trust Fund for construction and modernization of new public health and primary care delivery sites in underserved urban and rural areas. The Secretary would also be directed to report every five years on the impact of this bill on achieving the goals and objectives in Healthy People 2000.

Transition. The bill's requirements would be phased in over the first 5 years after enactment.

Year 1. Secretary of HHS develops regulations and guidelines; NAIC develops small group market health insurance reform standards

Year 2. Medicaid coverage extended to all pregnant women and infants below 185 percent of poverty at 100% Federal expense. States must legislate small group market health insurance reforms [check].

Year 3. Public plan begins operation, enrollment available to all. Large employers (more than 100 employees) required to offer private coverage for basic health services to employees and families or to enroll them in public plan. State benefits mandates preempted for large employers. Carriers may not market unqualified health insurance products to employers. Private payors have option to use public plan payment rates in purchasing basic health services. Survey of coverage among employees of small firms (less than 25 but more than 4 employees) to determine percentage target for coverage of uninsured workers.

Year 4. Medium-size employers (more than 24 but less than 101 employees) required to offer private coverage for basic health services to employees and families or to enroll them in public plan. State benefits mandates preempted for medium-size employers. Small group market reforms effective. Coverage among employees of small firms re-surveyed to determine whether target for coverage of uninsured workers is met.

Year 5. All Americans required to have coverage for basic health services through (1) employer group health insurance, (2) public health insurance plan, or (3) individual qualified health insurance policy. If small employers do not meet target for coverage of uninsured workers, they are subject to same "pay or play" requirements as large and medium-size firms.

Testimony of the Honorable Pete Stark
Chairman, Subcommittee on Health
Committee on Ways and Means
Before the Committee on the Budget

June 19, 1991

"The MediPlan Act of 1991"

The American health care system is currently right on track to achieve the dubious accomplishments of leaving fifty million Americans without health protection while ringing up costs in excess of $1.5 trillion by the year 2000.

We can stand back and do nothing, or we can act to assure that these outcomes do not come to pass.

Access to health care should be considered a basic right of every American. Unfortunately, it appears that we slip further away from assuring this right every year.

Almost thirty-four million Americans currently lack health insurance, and another seven to ten million Americans are covered by inadequate plans. As many as sixty-five million lack health insurance at some point during the year.

And while more and more Americans find themselves without health insurance, the system keeps spending more and more and more dollars, as if there were no limits. If we don't do something, we will bankrupt our industries and price our products out of the international marketplace.

A national strategy is necessary to provide all Americans basic and affordable health care. Unfortunately, other approaches, including the employment-based plan recommended by the Pepper Commission, would <u>not</u> be truly comprehensive. Only a single payer plan under public auspices can assure every American a basic level of health services.

For example, under an employment-based plan, children may be particularly vulnerable. Changing family patterns create equity problems with employer-based plans and often leave children or spouses without the coverage they need. Only a public plan can assure that all children are covered and that payment on their behalf is shared equitably.

Part-time and seasonal workers may also fall through the cracks in an employment-based system. It is unclear how such an employment-based system would help those individuals who change jobs, are employed by more than one employer, or are unemployed for some period during a year.

A national plan is also critical for cost containment. Through a single national plan, operated by the Federal government, it is possible to build upon the fiscal discipline that we have achieved in Medicare. An employer mandate approach would continue the ineffective patchwork approach to controlling costs of the current system.

Because I am convinced that a national strategy is necessary to provide all Americans basic health services and implement meaningful cost containment strategies, I have introduced the MediPlan Act of 1991 (H.R. 650) to provide publicly-financed health insurance to every American.

The MediPlan Act of 1991 will assure vital health insurance protection to every American. Its enactment would make real every American's basic right to high-quality health services and would control skyrocketing health care costs. All residents of the United States, rich or poor, would be enrolled in MediPlan and eligible for health benefits.

Enactment of MediPlan will achieve a priority goal of the American people -- universal access to health care. And it will do so in a responsible, cost-effective manner which builds upon the proven strategies of Medicare in order to control costs.

MediPlan's basic benefits would be similar to those currently provided to the elderly by Medicare. In addition, MediPlan would cover all children and all pregnant women without payment of a premium and without copayments or deductibles. Benefits would include needed pre-natal, labor and delivery, and preventive well-child care, including immunizations. MediPlan would also provide additional, essential benefits, such as prescription drug coverage, for low income Americans, who would also not pay premiums, copayments or deductibles.

MediPlan is not based upon ideas borrowed from another country. Its basic design was developed by the Congress and the Kennedy Administration in the early 1960s. In fact, at the time Medicare was developed, many believed that it would be expanded to phase in coverage of other groups.

It is also true that MediPlan does not require the design of a new system from scratch. All of the administrative mechanisms already exist.

MediPlan also provides for responsible, workable cost containment. Through the use of Medicare's DRG-based prospective payment system (PPS) for hospitals and through volume performance standards and resource-based relative value scale (RBRVS) for physicians, MediPlan builds its cost containment strategy on the only proven cost containment system. It is important to recognize that Medicare is the most successful health insurance program in this country.

This is somewhat different from our usual view of Medicare. The more common view, expressed frequently during reconciliation debates, casts Medicare in the role of a government program whose costs are out of control. The truth is that, when compared to other insurance plans, Medicare is a virtual model of effectiveness and efficiency.

We have done a better job of providing benefits, assuring access to care, and controlling costs than any other public or private health insurance plan in this country. This is a record that can, and should, be built upon as the basis of a program of universal access for all Americans, and that is what I propose to do through MediPlan.

MediPlan is budget-neutral; the proposed legislation raises the revenue necessary to cover its cost. Through a combination of employer and employee-paid premiums plus a new tax on gross income, MediPlan provides a blueprint of how comprehensive health benefits for every American could be financed.

To finance the basic health benefits, every person with income above the poverty line would pay their share of the MediPlan premium (the total premium is about $1,000/person) through the income tax system. Every employer would pay eighty percent of the MediPlan premium on behalf of each working American through a payroll tax of about $.40 per hour to a maximum of $800/year per employee. Thus, each full-time worker would be responsible for $200 of the annual premium.

Low-income persons would not pay the individual's share of the MediPlan premium. Between $8,000 and $16,000 for individuals and $16,000 and $32,000 for married couples, the individual's share of the MediPlan premium would be phased in.

MediPlan requires $65 billion in revenues beyond the payment of the MediPlan premium to support health insurance for children, pregnant women, and low-income persons.

To cover the $65 billion in benefits, revenues would be raised under MediPlan through a two percent tax on gross income, including tax-exempt income, deferred income and other forms of income not currently subject to taxation. Individuals with incomes below 200 percent of the poverty level would be exempt from the tax. All revenues from the MediPlan income tax would be paid into the MediPlan Trust Fund.

MediPlan's health care benefits would provide a true health care safety net for every American. I suspect that most will embrace the benefits included in this bill, but not support the proposed taxes necessary to fund the benefits.

To talk about the benefits without considering the costs and how to pay for benefits is to mislead the American people. I would urge those who object to the financing proposal to offer one of their own, or suggest areas where benefits of the program should be reduced.

I hope that my plan will move the debate forward, so that the 102nd Congress can enact the major changes the country so desperately needs. I look forward to working with my colleagues on the Budget Committee to achieve that goal.

STATEMENT OF THE HONORABLE NANCY L. JOHNSON
BEFORE THE
COMMITTEE ON THE BUDGET
U.S. HOUSE OF REPRESENTATIVES
"HEALTHCARE COST AND ACCESS"
June 19, 1991

Mr. Chairman, thank you for the opportunity to appear before you and your colleagues on the Budget Committee to discuss the health problems facing our nation today--the "trilogy" of access, cost, and quality.

We can be proud the United States offers the highest quality medical care in the world, the best technology and pharmacology, the most sophisticated medical providers. But we must be ashamed of the system's failure to serve millions of working and non-working poor, and appalled at the spiraling costs that increasingly threaten those with, as well as those without, health insurance.

Twenty-eight million workers and their depends are uninsured and ineligible for publicly-funded care. Another 6 million individuals and their dependents lack both work and eligibility for publicly-funded care. This means low income pregnant women go without prenatal care and millions of children don't receive basic immunizations, to give just two examples of the severity of the problem.

While poll after poll show how concerned the public is with rising healthcare costs, those same polls reveal no understanding of the dimensions of the challenge we face nor of the formidable trade-offs inherent in achieving an affordable national health policy that guarantees universal access and controls healthcare costs.

The cost crisis in our healthcare system did not happen overnight. Our best efforts to stem healthcare cost increases over the past decade through government price fixing in Medicare, Medicaid, and the VA system have met with failure, albeit periodically masked as short-term success. Healthcare costs continue to rise at rates substantially higher than the rate of inflation. U.S. healthcare costs are now over 12 percent of our gross national product (GNP) and, by some estimates, will rise to 20 percent of GNP in the not too distant future.

It is imperative that we correct the access, quality and cost problems with our healthcare system. But we must not destroy the remarkable strengths of our system as we correct its weaknesses. The challenge before us is how to retain the high quality of our healthcare system and still make it available and affordable to all. This will not be easy to do. Radical reform is not imminent and in my opinion not appropriate. There are many technical, structural and ideological issues that must be addressed. Making responsible and constructive changes affecting up to one-fifth of our nation's economy takes time and is best done incrementally. Being an incrementalist makes me the radical at this table because I fervently urge action NOW. There are reforms we know enough to adopt. They are reforms that will make a difference in peoples' lives tomorrow. They are solutions that address real problems but preserve real strength that Americans value.

Introduced by myself and Rod Chandler (R-WA), the **Health Equity and Access**

Reform Today (HEART) Act (H.R. 1565) would reform the small group health insurance market thereby making low-cost, basic office and hospital overage available to the nearly 20 million workers and their dependents without health insurance. Costly state mandates would be overridden in order to make an inexpensive plan available to small business and all variants of the basic plan would be free of state mandates for the small group market as long as they

- o don't exclude for pre-existing conditions after initial acceptance,
- o limit rate increases,
- o guarantee renewal except for non-payment of premiums, and
- o conform to certain public disclosure and certification requirements.

We could write significant legislation reforming the small group market this year. I hope we will not duck the challenge, so to speak. Secondly, we could reform our tax code to do two very important things:

- o encourage cost conscious purchasing of healthcare through managed care and employee cost-sharing strategies, and encourage insurers to make such plans more broadly available in the marketplace and
- o extend to the self-employed the same right to deduct cost-effective health insurance benefits that other employers would receive under the bill. This not only expands access but enhances policy equity and works to reduce cost-shifting.

The HEART bill addresses the need for medical malpractice reform by establishing "Quality 2000" guidelines for a comprehensive electronic utilization review system. This will enable hospitals and others to collect and make use of the information so critical to assuring value for each health dollar spent, eliminate unnecessary testing and procedures.

Thirdly, for those individuals and families who, even under the HEART plan's tax reforms and small business insurance reforms could not obtain affordable healthcare coverage, the HEART bill would expand community health centers to assure neighborhood access to the low-income uninsured. It's a dirty little secret that even with the recent series of eligibility expansions in Medicaid, fully 61 percent of families below 200 percent of the federal poverty level remain uninsured and ineligible for Medicaid. These centers would bring quality physician and outpatient care directly to those most in need. They would provide the linchpin for an essential neighborhood network that could offer family support services, drug treatment services and access to such important preventable health services as WIC. Since they offer care to all, charging fees related to income, they can assure healthcare access to everyone in the near future if allowed to expand. A set-aside for rural areas can work with and complement the EACH's and PEACH's programs to re-create the family medical care institutions so eroded by the problems of today's system.

One additional, important reform is that HEART would shield community health centers from exorbitant professional liability premiums. Despite the

fact that almost no malpractice claims have been filed against these centers, funds that should be used to provide patient care for the poor are being siphoned away to pay for malpractice insurance. This reform alone would free up $58 million--or 10 percent--a year in direct federal support, ensuring that an additional one-half million individuals could be served.

This brings me to H.R. 1004, the **Ensuring Access Through Medical Liability Reform Act.** By changing the laws covering medical malpractice, we can increase access to healthcare, ensure access to justice, reduce healthcare costs, and improve quality of care. These aren't just "apple pie and motherhood" claims. States which have already adopted such reforms have seen a reduction in the time and costs of deciding claims. Indiana and California have seen malpractice insurance premiums fall after reforming their medical malpractice laws.

My bill will make it easier and cheaper to resolve malpractice claims so that more people will have access to fair compensation. States are called upon to move toward alternative forms of resolving disputes, such as mediation, voluntary or binding arbitration, or early offer and recovery mechanisms. By creating an environment where even small claims can be heard and victims compensated, we will be able to identify and "weed out" poor practitioners early in their careers and prevent more serious malpractice.

Malpractice reform will not only create equal access to justice and allow early identification of poor practitioners, it will also reduce the cost of practice by limiting attorneys' fees and placing caps on non-economic awards. Some estimate as much as $30 billion a year in defensive medicine costs. Over utilization of services is part of defensive medicine. And overutilization of services is one of the most intractable problems contributing to the size of our healthcare expenditures. It's wise to remember as we think reform, that Americans pay 10 times more for malpractice insurance than Canadians. That's real dollars but, more importantly, that indicates an environment in which over utilization is done for the safety and survival of practitioners.

Medical malpractice reform to stem the rising tide of defensive medical practices, "Quality 2000," and reform of the tax code to broaden coverage and focus tax expenditures on "purchasing value" strategies, can attack the causes of healthcare cost inflation NOW and not simply treat the symptoms.

There are no easy solutions to our healthcare crisis. But we can and must assure that the 34 million Americans presently without health insurance will have access to quality care. The cost of care must be affordable -- to the individual, to the employer, and to the taxpayer -- and the quality of care must remain high. This means making sure that the care is appropriate to the problem, that the right numbers and types of providers and technologies are available, and that those providers are qualified to do the job. And lastly, the system must maintain the quality we are world renown for and provide choices -- for that is what America is all about. I believe H.R. 1565 and 1004 will do just that.

Thank you again for the opportunity to testify today. I would be happy to answer any questions you have.

PREPARED STATEMENT OF HON. MARTY RUSSO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

I appreciate having the opportunity to testify before my colleagues on the Budget Committee on behalf of my proposal for health reform, H.R. 1300, the Universal Health Care Act of 1991.

Everyone agrees: our health care system needs reform. A universal, single-payer health care system is the obvious answer to our nation's health care dilemma.

And I'm not the only one that has such faith in a universal, single-payer system. Both the General Accounting Office and the Congressional Budget Office have testified that single-payer is the ONLY system that can guarantee universal, comprehensive health care to 100 percent of the population and do so for LESS than we spend right now on health care.

A single-payer system achieves these remarkable savings by making our health care system more efficient. My constituents complain constantly about skyrocketing health insurance premiums and mountains of incomprehensible paperwork generated by our inefficient system. This kind of waste resulted in administrative expenditures of between $125 billion and $160 billion last year. This means up to 24 cents of every dollar spent for health care was wasted on administrative and billing costs.

According to a recent GAO report, shifting to a single-payer system would save the U.S. $67 billion in administrative costs alone. Insurance overhead would be cut by $34 billion while hospital and physician administrative costs would be reduced by $33 billion. Furthermore, the GAO anticipates substantial savings through global budgeting, fee schedules, and controls on expensive technology. These savings wold be more than enough to finance high-quality health care for all Americans and to eliminate all copayments and deductibles.

The legislation I have introduced would implement the key features supported by GAO in its report. H.R. 1300, the Universal Health Care Act of 1991, would establish a universal, single-payer health program which would cut the nation's health care costs while guaranteeing comprehensive, high-quality health care for all Americans.

Let me make this clear, my proposal is not the Canadian system; it's an American system. It's about the things we, as Americans, hold dear and have come to expect -- freedom of choice, quality care, and the efficient and fair use of our hard earned dollars. This bill is about containing costs because Americans can't afford to pay $5500 for every man, woman, and child by the end of the decade. Above all, it's about giving Americans the peace of mind they deserve so that when their children are sick they can take them to the doctor without having to worry about paying a high deductible. Or that when they change jobs, they won't lose their health insurance. Or that when their mother or

father needs long-term care, they won't have to mortgage their home or postpone their kids college education.

My proposal would cover all Americans for a wide range of benefits including hospital and physician care, long-term care, prescription drugs, mental health services, dental care, and preventive care. The ability of working and middle-income families to afford care would not longer be limited by copayments and deductibles. Hard-working parents would no longer have to worry about taking their child to the doctor immediately or waiting until the fever gets high enough to justify the expense. Consumers would still be free to choose their own doctors, hospital, or health care provider.

We can't afford to do anything less than single-payer. Partial solutions like insurance reform or mandated benefits won't work because they would allow insurance companies to administer health care. Insurance companies would continue wasting billions on paperwork and would be unable to implement meaningful cost containment. These means costs would continue to skyrocket, pricing more and more Americans out of the health care system.

As GAO has testified, the only way we will ever slow health care inflation in the U.S. is through comprehensive reform. And as CBO testified before the Ways and Means Committee, single-payer is the only system that can provide high-quality health care to all Americans without increasing the amount we spend on health.

Americans trust and respect their doctors and nurses, but they are fed up with the wasteful way insurance companies manage our health system. Opinion polls indicate that 89 percent of Americans believe our system needs fundamental change. Not surprisingly, a majority of Americans say they would prefer the Canadian system of health insurance where the government pays most of the cost of care for everyone out of taxes, and the government sets all fees charged by doctors and hospitals to the current U.S. system.

I'm tired of hearing everyone with an inside the beltway attitude say that single-payer is the best system, but it could never happen in the U.S. The American people want it and they deserve it. For the amount of money we spend, Americans should be living two years longer than Canadians, not the other way around.

H.R. 1300 has the support of 42 members of Congress, as well as 10 major unions, Citizen Action, several consumer activist groups, the National Council of Senior Citizens, and the Physicians for a National Health Care Program. My proposal offers the framework for how health reform should be structured to guarantee that America truly has the best health reform system in the world, not just the most expensive.

I look forward to working with all of you and welcome suggestions for improving my plan. I'd be happy to try to answer any questions you might have.

(Charts and description of H.R.1300 attached.)

The Russo Bill Highlights

ajor Provisions

- *Universal access to health care* through a single, publicly-administered program.
- *Comprehensive benefits for all Americans*, including hospital and physician care, dental services, long-term care, prescription drugs, mental health services, and preventive care.
- *No financial obstacles to care* -- no cost-sharing, no deductibles, no copayments.
- *Freedom of choice* so that everyone can choose their own physician or source of care.
- *Cost savings* through annual budgets and a national fee schedule so that health dollars are spent efficiently and effectively.
- *Progressive financing* to make health care affordable for all.
- *Quality* measures to improve the type of medical care we receive.
- *Uniform federal standards* to guarantee that all Americans receive full access to comprehensive, quality care coupled with state administration so that implementation decisions reflect local needs.

lajor Benefits

- People get the health care they need, rather than the health care they can afford or their insurance company is willing to pay for.
- The nation saves $40 billion in health care costs (and those savings grow over time) by substituting a single, publicly-administered and publicly-accountable program for the more than 1500 private insurance plans now in place. A single plan gets rid of paperwork, marketing and advertising, and other costs caused by the insurance industry.
- Senior citizens save $33 billion -- one-third of their current health costs -- and get long-term care, prescription drug, preventive and other new benefits.
- The non-elderly save $25 billion and won't have to worry about rising insurance premiums, cost-shifting, paying for children's health bills, or losing health coverage if they change jobs.
- Businesses that provide health care benefits to their workers lower their costs, can compete more fairly in the world market, and have more funds available to improve their operations and create jobs.
- State and local governments save $7 billion and no longer face the devastating budget impacts of unexpected and skyrocketing health care costs.
- Physicians, nurses and other providers spend more time caring for patients instead of filling out insurance forms and justifying their medical judgments to insurance company bureaucrats.

Health Care Spending Goals By Sector
1989, Russo Bill ($ Billion)

Sector	Current	Russo Bill	Change	Notes
Business	**$176**	**$199**	**+$23**	
Employee Health Insurance	$129	$0	-$129	Eliminated
HI Payroll Taxes (Employer Share)	$31	$169	+$138	Increase by 6 percentage points; no wage cap
Workers Comp (Medical Costs Only)	$14	$0	-$14	Eliminated
In-plant Health Services	$2	$2	$0	Retained
Corporate Income Tax Increase	$0	$27	+$27	Top rate up from 34% to 38% for businesses with more than $75,000 profits; $15 billion in reforms
Non-Elderly	**$135**	**$111**	**-$25**	
Out of Pocket Payments	$71	$28	-$43	No out of pocket for covered services (including long term care); items like over the counter drugs not covered.
HI Taxes (Employee Share)	$37	$38	+$1	Current 1.45% tax retained, extended to all workers
Private Insurance for Covered Services	$28	$0	-$28	Eliminated
Personal Income Tax Increase	$0	$45	+$45	New 15%-30%-34%-38% rates; $8 billion in reform
Elderly	**$84**	**$51**	**-$33**	
Out of Pocket Payments	$54	$15	-$39	No out of pocket for covered services (including long term care); items like over the counter drugs not covered.
Private Insurance for Covered Services	$18	$0	-$18	Eliminated
Medicare Part B Premiums	$11	$18	+6	New long term care/health premium equal to Part B premium plus $25/month for those above 120% of poverty
Added Tax on Benefits	$0	$6	+$6	Part of Social Security benefits included as taxable income; includes low income protection
Personal Income Tax Increase	$0	$12	+$12	New 15%-30%-34%-38% rates; $6 billion in reforms
State and Local Government	**$83**	**$76**	**-$7**	
Medicaid & Other Public Programs	$62	$54	-$8	Maintain 85% of Medicaid effort; $85 per capita fee; maintenance of noncovered services
Employee Health Insurance	$17	$0	-$17	Eliminated
HI Taxes (Employer Share)	$4	$22	+$18	All workers covered; rate up 6 pct. points; no wage cap
Other Private (Charity etc)	**$16**	**$16**	**$0**	
Federal Government	**$96**	**$96**	**$0**	
Health Programs (Net)	$88	$96	+$8	Maintain current effort, including employee health costs
Employee Health Insurance	$8	$0	-$8	Eliminated
Total Health Spending	**$589**	**$549**	**-$40**	

The Russo Bill
Impact on Businesses that Now Provide Health Insurance

Major Provisions

- Replaces current employment/private insurance system with publicly-administered program.
- Replaces current business costs of providing employee health care -- including health insurance premiums for current workers and retirees, self-insurance costs, and workers compensation -- with a 7.5 percent payroll tax and an increase of 4 percentage points in the corporate income tax rate on the most profitable firms.

Major Benefits

- Eliminates competitive disadvantages -- domestic and international -- faced by companies providing health coverage for their employees.
- Allows businesses to hire whomever they want -- without worrying that hiring an older person or someone with a preexisting condition will raise insurance costs
- By controlling runaway medical inflation, eliminating waste and requiring that all businesses contribute their fair share, businesses now providing health benefits will save money, allowing them to improve their operations and expand job opportunities. (Currently, over 90% of after-tax profits are spent on health benefits, up from 74% in 1984 and 14% in 1965).

Average Health Benefit Costs and Savings as a Percent of Payroll for Companies Currently Providing Health Benefits, 1989

Industry	1989 Payroll Costs	Payroll Cost Savings	Industry	1989 Payroll Costs	Payroll Cost Savings
Total All Industries	11.6	4.1	Machinery	7.4	-0.1
Total, All Manufacturing	12.1	4.6	Elect. Mach., Equip & Supplies	11.2	3.7
Food, Beverages and Tobacco	9.3	1.8	Transportation Equipment	13.7	6.2
Textile Products and Apparel	9.4	1.9	Instruments and Misc	11.0	3.5
Pulp, Paper, Lumber, & Furn.	10.4	2.9	Total all Non-manufacturing	11.3	3.8
Printing and Publishing	8.0	0.5	Public Utilities	13.7	6.2
Chemicals and Allied Products	14.8	7.3	Department Stores	7.0	-0.5
Petroleum Industry	10.3	2.8	Trade (Wholes. & other Retail)	12.9	5.4
Rubber, Leather and Plastic	15.7	8.2	Banks, Finance, etc	7.7	0.2
Stone, Glass and Clay Products	10.6	3.1	Insurance	10.0	2.5
Primary Metal Industry	14.4	6.9	Hospitals	10.1	2.6
Fabricated Metal Products	19.3	11.8	Misc Nonmfg Industry	10.0	2.5

NOTE: Calculations based on 1989 survey of approximately 1,000 companies by U.S. Chamber Research Center, Employee Benefits, 1990 Edition. Includes employer HI tax liability and medical component of workers' compensation, but not corporate income tax liability data, for which data was not available.

The Russo Bill
Impact on a Family of Four

Major Provisions

- Provides families with full access to comprehensive medical care -- including preventive care, prescription drugs, and long-term care -- at the physician, hospital or provider of their choice.
- Prohibits deductibles and copayments for covered services.
- Eliminates private health insurance and out-of-pocket costs for covered services, retains the current 1.45% HI payroll tax, and increases personal income tax on top brackets

Major Benefits

- Non-elderly families and individuals save $25 billion in insurance and out-of-pocket costs.
- All families are guaranteed full health care, including annual checkups, dental care, immunizations and prescription drugs.
- Coverage cannot be lost or reduced because of changes in employment or health status.
- Families will no longer have to rely on private insurance companies to provide affordable coverage and approve their claims or face the threat of financial disaster if someone gets sick -- all costs are fully covered by the national health plan.

Changes In Personal Income Taxes and Average Health Care Savings for a Family of Four, 1990 Income Levels

Income Level	Personal Income Tax Increase	Average Out-of-Pocket Health Care Savings
Lowest 20 percent (Average income = $12,800)	$0	$930
Second 20 percent (Average income = $27,400)	$0	$1,440
Third 20 percent (Average income = $39,200)	$0	$1,590
Fourth 20 Percent (Average income = $54,000)	$50	$1,750
Next 15 percent (Average income = $81,600)	$460	$2,020
Next 5 percent (Average income = $273,100)	$12,290	$2,620

Note: These figures are for non-elderly families of four. Current health care costs covered by plan include covered out of pocket expenses (including insurance). Tax figures assume no special break for capital gains (treated as regular income) and additional personal income tax reforms affecting high income families.

The Russo Bill
Impact on Senior Citizens

Major Provisions

- Provides comprehensive coverage, including long-term care, home care, prescription drugs, and preventive services not now covered by Medicare. There are no copyaments or deductibles.
- Senior citizens contribute to the National Health Trust Fund through a monthly long-term care/health premium (equal to Part B premium plus $25/month), an increased personal income tax on those in the top income brackets, and a provision to increase the portion of Social Security benefits included as taxable income.
- Senior citizens with incomes below 120% of poverty do not pay the monthly premium and are not affected by the Social Security or personal income tax changes.

Major Benefits

- Saves senior citizens $33 billion in current health care costs.
- Eliminates out-of-pocket costs and balance billing for covered services; gets rid of Medicare deductibles and cost-sharing.
- Protects those now facing cutbacks in coverage and/or increased cost-sharing as businesses reduce retiree benefits.
- Protects retirees from losing health care benefits if their firm goes bankrupt.
- Eliminates the need for Medigap insurance.

Average Net Savings from Russo Bill
For Senior Citizens Not on Medicaid

	Single Households		Married Couples	
	Median Income	Net Savings	Median Income	Net Savings
Lowest Fifth	$5,370	$1,120	$11,958	$2,161
Second Fifth	$10,548	$1,131	$26,238	$2,159
Middle Fifth	$13,520	$1,424	$39,631	$2,165
Fourth Fifth	$22,843	$1,717	$55,603	$2,518
Highest Fifth	$62,801	$1,086	$133,414	$2,878

Note: Net savings are based on a comparison of average household spending for taxes, Medicare premiums, and out-of-pocket expenses.

DESCRIPTION OF THE RUSSO UNIVERSAL HEALTH CARE PLAN
H.R. 1300

This proposal would establish a national, single-payer health insurance program that would cut the nation's health care costs, while guaranteeing comprehensive, quality health care for all Americans.

Benefits and Eligibility

The federal government would provide health insurance for all U.S. citizens. Citizens would receive a health insurance card entitling them to the national health insurance benefits.

These benefits include:

- All medically necessary hospital services (with a 45 day limit for mental health services)
- Nursing facility services
- Home health services
- Hospice care
- Medical and other health services furnished by health care professionals authorized to provide services under state law (with a limit of 20 outpatient psychotherapy and counseling visits a year)
- Dental and vision services
- Prescription drugs
- Preventive care
- Home and community-based services for persons with difficulty performing at least two activities of daily living (ADLs)
- Other medical or health care items or services as the Secretary of Health and Human Services determines to be appropriate.

There would be no coinsurance or deductibles and consumers would be free to choose their own doctors, hospital, or health care provider of their choice. Providers would be prohibited from charging more than they received from the government.

Payments to Providers

Hospitals and nursing homes would be paid monthly based on prospective global budgets established annually through negotiations with the designated government agency and reviewed by State Advisory Boards. Payment for capital-related items and direct medical education would be budgeted and allocated separately.

Physicians and other health care professionals would be reimbursed according to fee schedules established by the Secretary of Health and Human Services and adjusted by geographic region. The Secretary would be advised on the fee schedules by the Physician Payment Review Commission and the Health Care Payment Review Commission.

Other health care facilities as well as home health services, home and community-based services, and group practices could elect to be reimbursed based on global budgets, fee schedules, or another approved prospective payment system, including capitation, provided their choice is approved by the designated government agency.

Administration

The Department of Health and Human Services would administer the program at the national level and the state could choose to administer the program at the state level.

Each year the Secretary of Health and Human Services would establish a national health budget and state health budgets specifying the amount to be spent for health that year and how that money would be divided among the provided services. These budgets would act as expenditure targets, so that if the budget for a service were exceeded, the Secretary could lower payments for that service the following year.

The Secretary would establish separate budgets for capital expenses and direct medical education, and specify how this money would be divided among the states. States would allocate these funds within their state to assure a fair and efficient distribution of resources.

The national budget would be increased every year based on inflation and growth in our Gross National Product. Advisory Boards representing both consumers and health care providers would advise on the implementation of this program at both the state and federal levels.

The Secretary or State may enter into contracts with qualified entities to process claims. Only one contract would be allowed per state.

Financing

The program would be financed through a new 6% payroll tax on employers, an increase in the corporate income tax from 34% to 38% for businesses with more than $75,000 in profits, increases in the personal income tax from 15%-28%-31% to 15%-30%-34% with a top rate at 38% for families with incomes over $200,000, reforms of the tax code, a long term care/health premium equal to the Part B premium plus $25/month for the elderly above 120% of poverty, an increase in the amount of Social Security benefits included as taxable income from 50% to 85%, state payments equal to 85% state Medicaid effort plus an annual per capita fee of $85, and federal contributions equal to current spending on health care.

All revenues collected for health care would be placed into a National Health Trust Fund and could only be used for health care expenses.

The attached chart illustrates the effect of the tax changes on business, the non-elderly, the elderly, states, and the federal government.

Quality of care

The bill would apply the outcomes research and practice guideline provisions recently incorporated into Medicare to the entire national health care system.

Other federal programs

Persons currently covered under Medicare, Medicaid, CHAMPUS, the Department of Veteran's Affairs health program, and other federal health programs would be covered under this proposal. All US citizens would be entitled to identical benefits from the health care provider of their choice.

PREPARED STATEMENT OF KAREN IGNAGNI

Mr. Chairman, members of the committee, thank you for this opportunity to testify on one of the most critical issues for working people and their families.

At long last, this nation has reached an important milestone in the century-long debate over health care reform.

The AFL-CIO has long been on record in calling for federal legislation to assure all Americans access to essential health care services at a price they can afford. Now, organized labor, organized medicine and many in the business community are offering proposals to achieve these same objectives. This represents true progress toward resolution of these problems.

We believe that the time is right for Congress to take advantage of this growing consensus and to take the lead in fashioning a program that will reduce health care inflation, expand access and improve quality of care.

We hope that you will achieve these objectives before this crisis does any more damage to American families, who have been called upon to absorb a major share of cost increases; American businesses that are attempting to do their fair share by providing health care coverage; and health care consumers who are frustrated with the paperwork burdens associated with the current system and, increasingly, concerned that they may be the victims of unnecessary tests and procedures.

In the coming months, you will struggle with an issue that has been the central question in health care policy debates for decades: What role should government play in health care. How you answer that question will determine the architecture of a proposed national health care system: whether it should be employer-based with a safety net for those not in the workforce; whether it should be a public system, similar to Social Security; or whether the system should be one of individual choice and responsibility.

How you answer the question on the role of government also will determine your proposals to contain costs: whether there should be a single national system of reimbursement; whether there should be more discretion given to providers; whether costs should be contained through managed care or some combination of these.

As part of its deliberative process, we would urge the committee to compare the cost and performance of the U.S. health care system to those of our industrial partners. Without exception, all of these countries have universal access to health care benefits with government-based reimbursement controls.

Recently, many of the interest groups that oppose reform have gone on the offensive and conducted studies with the goal of demonstrating that specific international systems should not be adopted here.

We urge the committee not to be distracted by the myths of rationing, excessive government bureaucracy and inferior quality that have long been advanced by those who oppose reform. Taken together, the health care systems throughout the industrial world provide incontrovertible evidence that it is possible to provide coverage to all Americans far more effectively and at a cost that is measured and contained.

In comparison to our industrialized partners, the U.S. health care system fails the tests of fairness and equity. We also fail the test of efficiency, which is apparent to both consumers and providers who are frustrated with red tape and paperwork. Even those who seek to preserve the current system can no longer defend the excessive overhead and administrative costs associated with our fragmented system.

In pursuing a "competitive" health care market, the U. S. has ended up with a system that operates on the principle of Social Darwinism. It punishes employers who provide health insurance to their workers by forcing them to, in effect, subsidize the health care of those who are employed by firms that seek a competitive advantage by refusing to provide such coverage. The system rewards purchasers with large groups or relatively young workers with short-term discounts, and it penalizes small employers and those with older, more experienced workers by forcing them to pay more for coverage. The system is replete with inefficiencies that have forced costs to rise sharply, and millions of Americans who are fortunate enough to be covered by health insurance have, as a result, suffered the financial burden of increased cost-shifting and reductions in benefits.

The view has long been held that, notwithstanding these structural flaws, the U.S. system provides better quality of care. But this too has proved to be another myth advanced by those who oppose change. It is virtually impossible to defend the high rates of surgery, the estimates of unnecessary tests and procedures, the relatively small attention paid to preventive care and the lack of technology assessment and the duplication of equipment in our current system.

A nation that seeks to be competitive in the 21st century can no longer continue down this road. On a per capita basis, we spend 40 percent more than Canada, 90 percent more than Germany and 125 percent more than Japan.

In short, the current crisis demands immediate action and the labor movement is united in its pursuit of fundamental restructuring of the system. Although we have drafted specific proposals for your consideration, let me be clear that the AFL-CIO is not committed to any single plan. Instead, our objective is to maintain an open mind and work with all who share our goals toward the development of legislation that can be enacted.

We have four essential goals: to contain health care inflation; to provide all Americans access to care; to overhaul administrative procedures and to solve the retiree crisis.

Contain the Growth in Health Care Costs

To achieve this objective, we urge Congress to establish a national commission composed of consumers, labor, management, government and providers to administer a single national cost containment program by:

- Negotiating payment rates to be used by all payors.
- Establishing a target for the annual rate of increase in total health care spending.
- Establishing a capital budgeting system to encourage the efficient distribution of capital, which will minimize the unnecessary duplication of equipment and reduce the large numbers of empty beds still in the system.

Access to Medical Care for all Americans

To achieve this objective, we urge Congress to:

- Establish a core benefit package to which all Americans are entitled.
- Require all employers, including the federal government, to contribute fairly to the cost of care for workers and their families.
- Put an end to the patchwork quilt of federal and state health care programs and establish one federal program for those not in the workforce, including the unemployed and those currently receiving protection through state Medicaid programs.

Reduce Waste, Red Tape and Paperwork

Recently, there has been a growing interest in reforming insurance practices in the small group market. While we support such long-overdue reforms, the AFL-CIO believes that far more needs to be done and that reforms should be developed by Congress -- not the states -- to assure uniformity across the country. Specifically, we believe regulation is warranted to:

- Put a stop to current insurance practices that keep individuals and employers out of the health system or force them to pay contributions that are disproportionately high. This would involve broad pooling of risk, minimum data requirements and standardized claims forms.
- Set minimum standards for entities offering so-called "managed care." This would eliminate much of the confusion in the market-place and level the playing field for organized systems of care that meet federal

requirements.

- o Improve quality of care by developing practice guidelines for physicians and a national strategy to reform the current system of handling malpractice disputes.

Solve The Retiree Crisis

The issue of retiree health care has become one of the most difficult at the bargaining table. The new accounting regulations put forth by the Financial Accounting Standards Board (FASB) that go into effect in 1993 would require companies -- for the first time -- to list on their Balance Sheets estimates of liabilities for providing health care benefits to current and future retirees. The new regulations have caused a number of employers to cut back coverage for future retirees or eliminate protection altogether. Such actions have already seriously increased the number of retirees without coverage and the problem is growing.

We believe that the most effective way of responding to this crisis is to make the age of eligibility for Medicare more consistent with the average retirement age. Specifically, we propose reducing Medicare to age 60. This would spread the cost of retiree health care over the entire population and no longer disproportionately penalize employers who have attempted to protect their retirees against the high cost of getting sick.

CONCLUSION

Our proposals are based on the experiences of millions of working men and women for whom the current health care system has become a nightmare.

They are the ones who feel the sting of repeated cost containment exercises that have done little to limit the soaring cost of health care.

They are the ones who are losing access to a health care system that purports to be the best in the world.

And they are the ones who face the prospect of injury and illness without any idea on how they will pay for the decent and humane treatment they deserve.

Mr. Chairman, there is real suffering going on out there. Nothing short of full scale reform will solve our problems. We have reached the stage where quick fixes no longer are possible and where "voluntary efforts" no longer offer promise.

For its part, the AFL-CIO is prepared to consider each and every proposal that purports to address the three issues of cost, access and quality. We are prepared to work with you and your staff and to work in coalitions with consumers, employers and providers to develop an approach to national health care reform that takes the best of the systems around the world and is "made in the U.S.A."

PREPARED STATEMENT OF DIANA C. JOST

Mr. Chairman and Members of the Committee, I am Diana C. Jost, Executive Director of the Blue Cross and Blue Shield Association. The Association is the coordinating organization for the 73 Blue Cross and Blue Shield Plans throughout the nation. Collectively, the Plans provide health benefit protection for more than 70 million Americans.

Since their inception in the 1930s, Blue Cross and Blue Shield Plans have been committed to developing and improving the nation's pluralistic health financing and delivery system. To that end, we work in partnership with consumers, employers, unions, health care providers and government. That commitment continues today as we address the complex issue of providing access to care for the nation's uninsured.

We welcome the opportunity to address the Committee on this important matter. In my testimony today, I will:

- Offer a historical context for the current access problem; and

- Discuss how we believe this country can build on the employer-based system to assure coverage for all Americans.

Historical Context

Mr. Chairman, we stand on the verge of making a series of major public policy decisions that will have far reaching impact on the health care delivery and financing system in the United States. We arrive at this juncture following public policy decisions made in the 1950s and 1960s that substantially changed the supply and demand for health care in America.

In the 50s and 60s, Congress felt the need to improve the capital structure of our system. The Hill-Burton Act was passed to increase hospital construction, and the National Institutes of Health was created to promote the development of health care technologies. In addition, we invested significant sums under the various health manpower grant programs to increase our supply of physicians, nurses and allied health professionals.

In the mid-1960s, having made substantial progress in improving the supply of health care services, the Medicare and Medicaid programs were enacted. This dramatically increased the demand for health care services. These decisions were made at a time when economic growth was in double digits and health care inflation did not exceed 6 or 7 percent.

By the 1970s, these decisions had set in motion a supply and demand reaction that fueled substantial inflation in the cost of health care. As general economic growth slowed, health care expenditures increased to about 10 percent of GNP.

During the last decade, economic growth slowed considerably while the rate of increase in health care expenditures and costs became a matter of serious concern.

It should be noted that the cost and utilization increases during the past two decades also have been driven by a variety of demographic and societal changes. They include an aging population, a dramatic rise in drug abuse and violent crimes and the costs associated with treating AIDS.

Meanwhile, significant advances continued in medical technology, further spurring demand for services.

Against this backdrop of increasing costs, government enacted programs to stem capital spending and began to rely heavily on Medicare payment strategies to reduce expenditures and influence provider behavior.

American business -- faced with increasing foreign competition -- searched for all possible means of controlling costs. Much hope was put in the use of capitated programs -- HMOs -- to control utilization. More recently, the focus has turned to use of managed care programs to get costs under control. And greater use has been made of deductibles and coinsurance to help hold down utilization.

Meanwhile, a significant change had taken place in the business structure. While the percentage of employees in large national corporations with dependable health care coverage programs decreased, employment in medium and small businesses increased. Many of these smaller firms, often operating on slim margins, found themselves unable to provide programs with adequate coverage or to provide any coverage at all.

By the mid-1980s, access had become a major public policy issue and is exacerbated by rising health care costs that totaled $690 billion in 1990 -- 12.2 percent of GNP.

In examining this problem, the Blue Cross and Blue Shield Association identified some underlying problems that needed to be addressed. Our position has been that the overall access problem was best addressed by undertaking the following:

- Reforming the Medicaid program to increase eligibility to all those who are below the poverty level and break the link to welfare programs so that low-income working people are eligible;

- Amending ERISA to treat self-funded and insured employers equitably and to provide preemption for state mandated benefits;

- Equalizing the tax treatment for self-funded employers; and

- Creating state high-risk pools, where necessary, for uninsurable individuals.

Where Do We Go From Here?

The Blue Cross and Blue Shield System believes that in addition to the steps we have recommended in the past, more fundamental reform is necessary. We came to this conclusion after reviewing the effects of past health policy decisions and continued increases in health care costs -- namely, the millions of American families who lack access to affordable coverage.

We made a commitment at that time to address this problem through the development of recommendations for federal and state action and the development of products that meet the particular needs of those currently without coverage.

Among our first steps was to develop a position to assure access in the most troubled segment of the insurance market -- the small group market. In January of this year, the Board of Directors of the Blue Cross and Blue Shield Association unanimously approved recommendations to reform insurance practices that will help small groups.

We are now committed to the challenge of finding ways to assure coverage for all Americans. We continue to believe very strongly that the pluralistic system is the best way to meet the health care needs of all Americans. This is a framework that helps assure Americans a degree of independence and choice, room for creative ideas, and the medical advances

and quality care they have come to expect. There are three broad steps that we must take to make our pluralistic approach more effective.

Step One: Make Coverage Available for All Americans

The Blue Cross and Blue Shield Association believes that all Americans and their families should be covered under either a private health plan or, for those unable to purchase private insurance, a public program should be available.

Given that over 80 percent of the approximately 37 million uninsured Americans are either workers or dependents of workers, we believe the best way to provide high quality health care that meets the needs of this population is through the employer-based system.

The employer-based system has served the American public very well in the past 50 years. It has the flexibility to respond to the needs and desires of both employers and employees.

Currently, we are examining how to make this system work better. To encourage more employers to purchase coverage, we recognize that the very real problem of affordability needs to be addressed. We also need to assure continuity of coverage by developing ways to assure that lapses in coverage are avoided as people move from one health program -- whether public or private -- to another. These are essentially "portability" issues.

Some parties have proposed to meet these objectives by establishing a "play or pay" system, under which employers either would provide coverage to their employees directly or be

taxed to finance their employees' coverage through a public pool. We have serious concerns about the concept of a public pool approach because we believe it provides incentives for employers to drop their commitment to providing coverage directly to their employees. A result, we believe, could be the elimination of employer-provided health benefits and a resulting total reliance on a universal federal program. We do, however, support what we believe is the intended objective of encouraging more employers to offer coverage.

The Blue Cross and Blue Shield Association also is considering how to address the coverage needs of non-working individuals. We believe a combination of public and private plans is appropriate. A key focus of our deliberations is how to maximize the use of tax subsidies to minimize reliance on public coverage and to bring private coverage within the reach of more lower-income individuals.

Step Two: Make Coverage Affordable

Throughout this testimony I have emphasized the overarching issue of affordability of coverage. To address this issue, it is necessary to consider both the absolute level of health care costs and the role that benefit design and subsidies play in the affordability equation.

Health care costs in the absolute sense are comprised of two factors: 1) the price per unit of service; and 2) the number of services used. Price is affected by such factors as practice patterns of providers, excess capital, costs associated with medical malpractice.

In general, we have been fairly successful in controlling price, largely through provider contracting. Blue Cross and Blue Shield Plans have a long history of controlling costs through contract arrangements with hospitals that limit

subscribers' liability while assuring an appropriate amount is paid for covered services. Plans also have contract arrangements with physicians that limit payments to amounts that are reasonable and protect subscribers from "balance billing."

However, our ability to control utilization has been affected largely by uncontrollable factors such as new technologies, demographic changes and consumer demand for health care services.

We have implemented and achieved success with a broad array of cost containment programs. They include: broad use of preauthorization of health services, concurrent utilization review, post-payment review, discharge planning, and individual case management.

We have sharpened our strategies for negotiating reimbursement rates and increasingly select providers in our managed care networks to achieve cost-effectiveness and quality care.

We continually update our medical necessity program that has targeted many outmoded, redundant, or ineffective procedures. We continue our technology evaluation program to help make sure that medical equipment, procedures, and drug therapies produce safe and effective results.

We are meeting the cost and quality challenge of organ transplants by identifying "Centers of Excellence" where these procedures are performed at reasonable cost by qualified physicians and skilled support teams.

During the past 20 years we have been highly successful in moving an increasing number of medical procedures from the costly in-hospital setting to the outpatient area. Now we are focusing on ways to control outpatient services as the cost of these services continues to increase.

Clearly, there are continual changes in the delivery of health care services, and they require constant adjustments and improvements that the private sector is in an ideal position to undertake.

Some parties in this debate have advocated an all-payor system as a way to reduce cost. We strongly oppose such proposals. We believe that current problems such as excess capacity and inefficiencies would become locked into place if payors are prevented from negotiating in the economic interest of consumers.

In addition, regulatory systems have not proven capable of differentiating among the numerous factors affecting a payor's total costs. Regulation may take some of these into account, but accounting for the total mix of utilization levels, administrative processes, surety of payment, level of coverage and other measures is beyond the scope of government systems. We believe that the most effective arrangements are those in which the parties at economic interest are free to negotiate and come to agreement on the price of services.

In addition to addressing these larger cost issues, we also must consider how to make coverage more affordable. This means making the best use of tax subsidies and assuring an efficient insurance market. As I mentioned earlier, we are examining how tax subsidies could be used to reduce reliance on public programs and mainstream lower-income individuals into private coverage.

A final consideration in improving affordability is the design of a benefit package. The Blue Cross and Blue Shield Association supports access to a basic set of benefits for all Americans, but we believe that the design of a benefit package must balance the competing needs of: adequate protection, affordability and incentives for appropriate use of services.

We do not believe that we can affect major changes in health care costs and assure affordability of coverage on our own. To achieve this goal -- and the corresponding objective of increasing access -- all of the parties involved must participate in the solution.

Step Three: Assure A Well-Functioning And Competitive Insurance Market

The Blue Cross and Blue Shield Association believes that to assure universal access through a pluralistic system, it is essential to have a well-functioning and competitive insurance market.

One action to improve the efficiency of the insurance market is to eliminate the current imbalances between self-funded and insured benefit plans. Because ERISA protects self-funded employers from state regulation, these employers are not required to provide state mandated benefits -- nor do they pay state premium taxes or share in the costs of state-run high-risk pools for individuals. These imbalances shift these costs onto insured employers, who tend to be small and medium-sized companies that can ill afford these additional costs.

However, we also recognize that market reform is necessary. To understand the nature of these reforms, it is helpful to understand how the health insurance industry developed.

The nature of private health insurance has changed as the insurance industry has grown. When Blue Cross and Blue Shield Plans began providing insurance coverage in the 1930s, every applicant was accepted for coverage, regardless of health status. In addition, all subscribers in a given area were charged the same price for coverage -- a practice known as community rating. In this way, the cost of coverage for

enrollees with the poorest health risks was kept at the most affordable level possible, because lower-risk enrollees heavily subsidized the costs of higher-risk enrollees.

However, as competition increased in the health insurance market, underwriting and rating practices similar to those traditionally used in other lines of business began to appear. These practices included screening out high-risk applicants, denying coverage to high-risk applicants and/or charging such applicants higher rates.

In this competitive environment, the insurers that continued to accept all risks, or had even marginally more liberal enrollment practices, ended up with a worse mix of risks. Consequently, they were forced to charge higher rates than insurers that had been more selective. These higher rates reflect the fact that only a few high-cost enrollees can generate substantial claims costs. On average, only 4 percent of insured individuals generate 50 percent of claims, while 20 percent of enrollees generate 80 percent of claims.

As insurers with more liberal enrollment practices adjust their rates to reflect their higher costs, they lose their low-risk enrollees -- who can find better-priced coverage elsewhere -- and keep their higher-risk enrollees, who have nowhere else to go. These carriers thus are left with risk pools that gradually deteriorate over time.

This phenomenon is known as the "adverse selection spiral" and it explains why few insurers can continue to accept high-risk enrollees and remain competitive. It also explains why more people are found to be "uninsurable" or insurable only at high cost.

The competition for the lowest-risk enrollees also involves pricing coverage at levels that more closely reflect the risk of a particular group or individual. The cumulative effect has

been an increasing segmentation of the insurance market, and a declining ability of Blue Cross and Blue Shield Plans to retain their early practices while remaining competitive in the market.

The increasing cost of health care also has diminished our ability to accept all applicants and to community rate their coverage. For many years, our Plans were able to continue their early practices, because they were able to offset the cost of high-risk enrollees by controlling overall costs. In addition to the cost management tools described earlier, Plans also had the advantage of provider discounts and preferred federal and state tax treatment. But, as these advantages have eroded, so too have Plans' ability to maintain their earlier practices in a competitive market. While a number of Plans continue to provide coverage on an open enrollment, community rated basis in the small group and individual markets, other Plans have had to change their practices in order to compete in their markets.

The Blue Cross and Blue Shield Association believes that reforms are necessary to replace competition based on ability to select risks with competition based on ability to control costs. Specifically, the Blue Cross and Blue Shield system supports:

- Assuring that small employers have access to private insurance, regardless of health status, occupation or geographic location;

- Assuring that states have a range of options to choose from in providing for the availability of private insurance to small employers;

- Assuring that small group coverage is provided at fairly established rates;

- Assuring that no small employer is dropped from coverage because of poor claims experience;

- Assuring continuity of coverage for small employers and their employees;

- Assuring the adequate effective enforcement of all carrier requirements;

- Assuring the equitable sharing among carriers of both high-risk small employers and the losses associated with covering these high risks; and

- Assuring the availability of lower-cost products.

With respect to assuring small employer access to private insurance, BCBSA believes that states should have the flexibility to choose an approach that meets the needs of their environments. One approach that has received a lot of attention would require all carriers to offer coverage to small employers on a guaranteed issue basis and is depend on a private reinsurance mechanism to help carriers spread the costs associated with high-risk groups.

While this approach may be appropriate in some states -- where participation in reinsurance is voluntary -- we believe it is equally important for states to be able to choose approaches that do <u>not</u> rely on guaranteed issue and a reinsurance mechanism. While we believe that this represents one option for states, we also support several alternative approaches. In general, these approaches would assure that all small groups had access to private coverage and that all carriers would comply with the requirements noted above.

As for access to individual coverage, our current position is that states whose Blue Cross and Blue Shield Plans do not provide coverage on an open enrollment basis to individuals should establish high-risk pools to provide access to coverage for uninsurable individuals. However, we recognize that changes may be needed in the individual market.

It is important to understand, however, that reforming the individual market will be much more difficult than reforming the small group market. Of all the health insurance markets, the individual market has the most severe problem of adverse selection.

In this market, individuals make choices about whether they need coverage and which type of coverage to buy based on their perceived or anticipated need. Thus, individuals who need medical care tend to choose the most comprehensive coverage available, while healthy individuals either choose lower-cost coverage or no coverage at all. And in contrast to the small group market, where a group may contain several healthy employees for every high-risk employee, high-risk individuals do not bring along with them other healthy individuals who may help offset their costs.

Before leaving this discussion of the insurance industry, I would like to comment on insurers' administrative costs. Many people point to the administrative costs of insurers as a target for cost-savings, and to question the "value" of a private health insurance system. Blue Cross and Blue Shield Plans are very proud of their record of providing an average of 90¢ in benefits for every $1 in health benefits premiums.

What Do We Do In The Meantime?

While we are debating what changes are needed in state and federal policy, many Blue Cross and Blue Shield Plans are taking steps in their communities to address the problem of lack of access. Examples of Plans activities include:

- Blue Cross and Blue Shield Plans in Virginia, Washington, Illinois, Kentucky and Oregon have developed low-cost products for uninsured small employers after working with their state legislatures to exempt

such products from at least some state benefit and provider mandates. For example, Blue Cross and Blue Shield of Oregon has created a special product for small groups that offers a PPO at a price approximately 33 percent lower than regular Plan products.

- 14 Plans have established a "Caring Program For Children," through which outpatient primary care is provided, free of charge, for low-income children not covered by Medicaid. The program provides preventive care and often diagnostic care and surgery as well. Premiums are subsidized by charitable contributions and by the Plans. To date, more than 30,000 children have been enrolled in the programs.

- Blue Cross and Blue Shield of the Rochester Area (NY) offers "ValueMed," a health care plan for low-income individuals that includes major medical coverage, prenatal and preventive child care. ValueMed is less than half the cost of the Plan's other products for individuals.

- Blue Cross and Blue Shield of Oklahoma has developed a product for uninsured individuals and families who are self-employed, employed by small companies or part-time workers. Indemnity inpatient and outpatient coverage is provided, as is coverage for maternity and psychiatric care. Premiums for small groups are 30 to 45 percent less than for other group products; premiums for individuals are 30 to 60 percent less than regular products.

Conclusion

In conclusion, we acknowledge that the problem of the uninsured population is very serious, and that it demands a concerted effort by the private sector and government. At the same time, we need to note that the problem has arisen because of a combination of demographic and societal changes that have created a broad array of other social problems as well.

The problem of the uninsured should not be viewed as an indictment of the private system of health care financing. The private system is meeting the health care financing needs of the overwhelming majority of Americans. It is developing and implementing a series of programs and initiatives to ease the problems of the uninsured.

We are ready and willing to move ahead with government to develop a series of well-planned, coordinated steps that will help assure access and control the increases in health care costs that have made access the serious problem it is today.

PREPARED STATEMENT OF GREGORY SHOW

Electro Management is owned and operated by Greg and Vicki Show. We specialize in electrical construction and have been doing so for almost thirteen years. We have grown from a small four person shop to currently employing approximately 25-40, depending upon the construction market or workload.

I am truly a small business owner and worker. I work in the office every day for at least eight to ten hours and at home. I am involved in nearly every decision made by our company. My wife handles the accounting department which consists of her and one fulltime accounting manager and clerical support from our receptionist. Vicki handles all of our legal affairs and is also responsible for all accounts payable and receivable. She also shops for all of our insurance - health, Workers Compensation, general liability and auto. Together, we decide which policies will best suit our business and employees.

At first we carried health insurance on only two key people in our company. We obtained a group policy with NECA (National Electrical Contractor's Association). The insurance was very good but very expensive due to the average age of the general NECA membership, which was 50. The plan itself excluded field employees, those who work at the construction sites.

In 1987, in an effort to attract and retain the best employees in the Palm Springs area, we decided to shop for a more cost effective plan so we could expand coverage. We found a good group policy and have been offering health insurance to our staff and field workers now for quite some time. In 1988, when we could afford to pay 100 percent for our employee's insurance, the approximate cost for a single individual, without dependents, was $87.00 per month. This policy included dental and maternity care with 80 percent of the bills for medical services covered by insurance, 20 percent employee responsibility and a $150.00 deductible. Today the same individual coverage costs over $150.00 per month.

Our insurance agent stated that in 1960 it cost approximately $18.00 per month to insure an employee and his family. Today the same coverage costs over $530.00 per month to cover that family - a 3000 percent increase. The following columns indicate our escalated costs indicating the percentage of increase our profits have not experiences a similar increase particularly with the building slump in southern California:

Year	Age Group	Single	Family
6/88	30-40 yrs.	$86.95	$285.30
6/89	30-40 yrs.	$106.74	$351.70
1/90	30-40 yrs.	$137.79	$455.32
7/90	30-40 yrs.	$151.06	$498.84
5/91	30-40 yrs.	$157.43	$531.46

In order to control costs and provide incentives to remain with our company, we phase-in the company's premium contribution over a period of time. When a new employee starts with us they become eligible for insurance after 30 days of continuous employment. After 30 days, they can participate in our health plan at their own expense. After six months, we pay 50% of the employee's costs, and at the end of one year's employment, we pay 100% of the employee's premium.

From the employee's stand-point this practice works well because they are insured almost immediately and rewarded for length of service, but it becomes burdensome to the company due to the increased costs. One problem with the arrangement is that after six months new employees are receiving an increase in salary and don't realize it. Eventually they come to us looking for raises and we have to tell them they just got one - and a substantial one at that. We have to try to explain to them that although they are doing a good job and have made the company more profitable, the profit was eaten up by their health insurance premiums.

In the past, the health insurance premium increase alone was ten times the amount of our increase in profits. Sometimes more than ten times! Further, many of our younger employees tell me "I would rather have the money and forget about the insurance." That poses a second dilemma for us. We do not give extra money to employees in lieu of insurance because we believe that all our employees should have insurance if they qualify.

Aside from premiums rising faster than our revenues we have one particular problem with our insurance. Currently we have a 60 year old employee who is eligible for fully paid health insurance. The cost to insure this employee is approximately 140 percent more than our average employee. This employee will become even more costly to us as his age increases and his efficiency decreases. Because of the health insurance benefit, he is actually earning more money than those who may actually be better electricians. Not that this affects our decision to give the older man insurance, but it does and has created dissention among his fellow workers. Given the fact that nobody is going to pay us any more on a contract to insure this man, the excess premium charges for him will have to come from excess profits (though I personally have never had experience with excess profits). We insure him - it is both our moral and financial commitment to him -- but it is a shame we have to pay more money, just because of his age, to meet this obligation to reward a valued, loyal employee. I can't imagine what will happen to premiums when our company starts getting older.

Perhaps if there were some way to average those premiums

paid for younger employees with those of older employees, it would prohibit the insurance companies discriminating against the older, proven employees.

Another predicament that we experienced in searching for affordable coverage was when the non-union sector of our local NECA chapter attempted to obtain quotations on group health insurance. Our intent was to be more attractive to insurance companies by banding together as a group, believing that because of the size of our chapter and the large number of employees when combined we could get a better price. We originally approached the insurance companies as a group because true group rates are not available to smaller companies and because we felt we would have strength in numbers needed to get an affordable rate. Unfortunately, there were two companies in the group that had employees with major health problems. One had AIDS and the other had some other sort of pre-existing medical condition. The insurance companies would not even give us a group price with these two companies as part of our group. Needless to say, neither of these two employers could change insurance companies or even get quotes from other agencies and their participation in the NECA group kept us from purchasing insurance.

The bottom line is simple. We provide health insurance because it makes us more competitive because we can and do attract better employees in an industry where maybe four out of five companies do not provide insurance. Health insurance is a valuable fringe benefit that helps us stick out in a crowd. We also feel it is our obligation to provide this benefit. The problem for us and other small employers, however, is with the rising cost of that insurance and a pricing system that discriminates against older workers or ones who may be sick.

In preparation for my trip to speak before your Committee, I contacted as many of my local business colleagues as I could to get their view on the health insurance issue. Also, as fate would have it, our business was also getting a quotation on health insurance. In my effort to gather my thoughts as well as the thoughts of others on this issue, one thing becomes very clear. This health insurance issue is one of the most complicated, confusing can of worms I could ever imagine. It was unanimous among my colleagues that there are no easy solutions but parts of the problem need to be addressed and addressed today. I also must say that health insurance is not as important an issue as the current state of the economy. Yet, perhaps, health insurance and/or the abuse of it is relevant to the <u>state of the economy</u> and is certainly relevant to our business' competitiveness.

In my talks, one general comment that emerged was that tort reform is essential. Doctors are angered with excessive judgments -- courts are awarding what doctor's feel are excessively high amounts of money for malpractice, and frankly this scares the doctors to death and I don't blame them. The

government must come up with some type of standard control mechanism to limit the financial awards given to people that file and win judgments. Limits must be set. The laws should be written to allow for a person to collect on expenses only and expenses not also reimbursed by insurance. "Pain and suffering" should be the exception, not the norm. I watch attorneys advertise asking if you have been hurt, come see me for no charge only if I win or settle your case will you be charged. So now when someone thinks they have a one in a hundred chance of winning, what the heck, let's try anyway -- it won't cost us anything. Then they call the lawyer.

Lawyers also refer clients to certain doctors and then tell those doctors to run tests the doctor knows he does not need to run. "We'll build up the case," the lawyer says. "Better run the MRI just to be sure." A doctor would be crazy to argue with a personal injury attorney. I personally believe if lawyers would start to use sound judgment and conscientious decisions, based on morals rather than the "All Mighty Buck," we might start to make a dent in this problem.

To me it is ethics. They have seen an area capable of producing big bucks for them and are taking full advantage with no concern for the effects it will have in the long run. If a standard or limit can be established on these awards, this would lower the cost of malpractice insurance and therefore lower medical expenses which in turn will help lower private and workers compensation insurance.

The second general issue of great concern is non-payment of medical services. Hospitals charge inflated rates to lower costs incurred by a staggering number of non-payment or underpayment claims, <u>particularly</u> by the federal and state governments. A hospital may have to recoup costs in one area, so it has to inflate charges on simple tests on uninsured patients that their doctor has ordered, raising costs for us all. The current answer to the cost shifting is simple - charge more money to those who have insurance and can "afford it." Our insurance agent cited an example where one of his clients went to a hospital to argue a charge that they thought was too high at $1,000. The hospital apparently did not know that this person did not have insurance. The bill was negotiated to an affordable $200.00.

I wonder which bill was fiction and which was fact. It is impossible to find the real costs because the federal and state cost shifting is so deep that it's hard to determine whether the hospitals can themselves cut costs somewhere. In any case I do believe that a hospital should get legitimate charges for the same services. I think it is intolerable that patients who care enough about themselves and their families to purchase insurance have to pay exorbitant charges because others are "free-loading." Just like in any business, if it cost $1.05 to do business, that $1.05 comes from someplace. It does not simply vanish into thin air.

SUMMATION

I believe that everyone must have some kind of affordable health insurance. I believe that every American should be legally bound to have some sort of health care coverage. If employers are not providing health insurance, then it should be up to the individual to obtain their own insurance. Individual responsibility is key. The idea behind this is that labor will realize how important health insurance is and move to companies who have it. If for some reason a person is unemployed and unable to afford insurance or "uninsurable," I believe the state should pay for coverage out of some sort of pool.

Along with this same view is also a strong feeling that business should not be mandated into providing health care insurance. It is the individual's responsibility. To mandate these costs will ensure that many small businesses would go out of business and jobs would be lost. Even the pay or play proposals are a mandate. We can do better than what the federal government tells us and we do not trust the federal government to spend these new dollars wisely. We should allow negotiations to occur on the type of benefits to provide. You simply cannot mandate businesses to take on these escalating costs and expect them to continue to operate.

Instead you must find a way to bring down the cost of medical care, set firm limits on malpractice suits which would in turn lower the cost of insurance, put together some sort of pool to help the insurance companies with the catastrophic and/or pre-existing condition cases, level out the cost to groups and individuals as a whole and remove government's negative impact on this marketplace.

Currently one of the most popular types of plan is called Preferred Provider Option (PPO). This plan is growing in popularity with insurance companies, doctors and the public in general. The insurance company recruits doctors and other health providers for their roster. Then all of their insured people go to see the appropriate providers on their roster. In the early stages of PPO programs, they were, in my opinion, ineffective due to the limited number of doctors on the roster. In rural areas such as the California desert, it was even less effective due to the selection of doctors being extremely low.

However, PPO's changed drastically in recent times, for the better, I might add. The number of doctors on the roster has increased due partly to the number of people that are members in PPO plans. Costs are pre-negotiated between providers and insurance companies, which guarantees payment to the providers. In summary doctors are seeing more paying customers and PPO plans

are becoming widely accepted. In addition, although very expensive, the cost for PPO plans is competitive. This is the right direction to go - it helps to control costs and gets care to those who need it because its affordable.

Another partial solution is to have a "CORE" plan available to any individual who is not covered by their employer's health plan. The "CORE" plan would be purchased directly by the individual and paid the same way. For unemployed or uninsurable the state would pay for it through a tax or fee at the consumer level. I feel most people would be agreeable to a small tax increase if it were to help bring about a solution to the health insurance problem. In addition, if a person was sick while unemployed, the state would pay any health care costs, thus guaranteeing payments to doctors and hospitals. This "CORE" plan should be more affordable, and should also be available in the private market.

With only a short amount of time to talk to other people about their feelings on health insurance, I was unable to get a full circle of opinions. First of all, without question, we all agreed that there must someday be an "overhaul" of our health care and insurance, from the very bottom to the top. Doctors order tests to "cover" themselves, just in case someday when the patient sued them, they could vindicate themselves by showing that they did every test known. It was news to me that the reason hospitals charge so much to insured patients is due to the practice known as cost shifting. This is to note that one way or another, as in any other business, a hospital will have to get a dollar for a service that costs a dollar to perform. With the rate cost shifting coming from Medical/Medicare, if the hospital doesn't get 100 cents on the dollar, they must shift the cost "underage" to another area. We need to stop this.

There must be reform and I believe insurance reform should begin first or a least a close second with affordability being the goal of that reform.

For the record I would like to introduce the following seven statements of:

J.W. Erwin of Erwin Farms (MI)

Teresa Matregrano of Blue Star Glass (NH)

Gerry Harkins of Southern Pan Services (GA)

Rod Starkey of Pacific Messenger Service (CA)

Eddie Mills of Mills-Anderson Opticians, Inc. (FL)

Don Summers of Austin Welder and Generator Service (TX)

Salvator Risalvato of Riverdale Sunoco (NJ)

James Jackson of Desert Contractor's Assn. (CA)

These statements represent the geographical scope of the country from the North, to the South, East to West. Some of these small business owners are uninsured, many provide insurance, all are grappling with the problem of pairing rising insurance costs with their bottom line. Or put another way -- what each have in common is the struggle to pay for insurance, provide for our employees and keep our businesses working.

TESTIMONY OF

J. W. ERWIN

ERWIN FARMS
NOVI, MICHIGAN

Before: Senate Finance Committee Field Hearing Panel

Subject: Affordable Health Insurance

Date: June 28, 1989

Good morning, Senator Riegle. My name is J. W. Erwin. My son and I own a fruit and vegetable market called Erwin Farms on 10 Mile Road in Novi. Erwin Farms is our family orchard and has been in operation since 1922. I opened the retail store in 1963. My brother now runs the Orchard. I would like to thank you for holding a hearing in Michigan to listen to small business problems in providing health care coverage for employees.

I am here today to tell my story and also to represent the 22,500 small business owners in Michigan who are members of the National Federation of Independent Business. About 84 percent of NFIB's members in Michigan employ 19 people or less, fifty percent have 5 employees or less. Finding affordable health insurance is a major problem for us.

Our store employs 18 people, including five family members. We have a good record of employment and have not laid off any people in years. Our employees become members of our business family and it's important that we help them in any way possible.

Our Blue Cross/Blue Shield coverage last year increased $50 a quarter per employee for a total of $200 per employee. Our coverage is through the Farm Bureau, of which I am a member and have been for years. If I did not belong to the Farm Bureau, the insurance costs would be even higher due to the small size of our business. Because of the cost of health insurance, I am only providing coverage for four of my full-time employees. Without the help from the Farm Bureau, I probably wouldn't be able to afford coverage for anyone.

It costs me $764 for three months of health insurance on one employee, or about $3,056 per year, not including expected premium increases. In computing what it would cost me to cover part-time employees, I find that for an employee who works 17 hours, insurance coverage would cost $3.16 per hour. If the employee works 20 hours a week, the cost is $2.69 per hour. The cost for this coverage on a full-time employee breaks down to $1.35 per hour. Since my part-time employees earn between $4.50 and $7.00 an hour, providing insurance would be almost doubling my payroll costs for those employees.

Several years ago, through our local Chamber of Commerce, we were able to get less expensive group coverage. The insurance was cheaper, but the benefits were not as good, and we returned to Blue Cross/Blue Shield through the Farm Bureau. There aren't many choices for us, and on my own it's too expensive.

I believe that much of the increased costs are due to doctors scheduling far more tests for patients through fear of malpractice suits. These additional tests not only add to the cost of each claim, but require our employees to be away from the business for much longer periods of time. This, too, costs us money.

In closing, I would point out that my employees receive health care coverage tax free. I pay 100% of the premium costs. However, to me--the employer--it is not tax free. Seventy percent of the cost comes out of my pocket--out of my profit margin, which isn't great to begin with. Also, as the cost increases, the employee does not see this as a pay increase, but it really is. It does not act as a reward and does not increase productivity like a regular pay increase would.

Our retail store sells primarily perishable items. We are directly competing with big supermarket chains like the A&P and Kroger which are less than a mile from my place. Last year our net profit was $39,000. If insurance costs continue to rise and government continues to mandate benefits, we will reach a point where it will no longer be profitable for us to stay in business.

When health insurance costs keep going up, they are either paid by what would be profits in our business or by the customers when they come in to buy our fruits and vegetables. This is totally inflationary! Those types of costs can't be completely passed on to my customers if I want to keep those customers, nor can I get rid of enough jobs to absorb those costs without hurting my business. Big increases in insurance put me and my business in a no-win situation.

Please help small business owners in Michigan and the nation to find a solution to this costly and burdensome problem. Small business owners want to provide health care coverage. They care about their employees and must provide good benefits in order to keep good employees.

There is a perception that all small business owners have deep pockets and can afford these costs, as their profits are high. In the average company, employee compensation is six times greater than profits -- six times as big. Seventy-five percent of our national income is paid out in compensation to employees. That's 75 cents out of every dollar.

Thank you, again, for taking time today to hear my testimony. I would like to submit the attached testimony from the NFIB for the record.

Attachment

WRITTEN
STATEMENT OF

NATIONAL FEDERATION OF INDEPENDENT BUSINESS

Before: Senate Finance Committee Field Hearing Panel

Subject: Affordable Health Insurance

Date: June 28, 1989

NFIB is a voluntary membership organization with over 580,000 small business owner members. Our membership comes from all of the industrial and commercial categories and reflects the national small business community in its distribution among industries. That is, we have about the same percentage of members in the construction industry, the manufacturing industry, wholesale, retail, etc., as exists in the national business profile.

For NFIB members like Mr. Erwin and their more than 7 million employees, much is at stake in the current debate over mandating health benefits. Mr. Erwin's statement expresses in real life terms precisely what our data explain in statistical terms--that despite the desire to help their employees, small firms are being priced out of the health insurance market and sometimes, out of business.

While NFIB is a recognized authority on small business, NFIB is not an expert in the health care industry or in the insurance industry, therefore remarks are primarily directed to a description of the attitudes and operational characteristics of the small business community that are relevant here.

NFIB has conducted three national surveys in this general area. The first was done in 1978 and is entitled National Health Insurance Report on Small Business. The second, conducted in late 1985, is entitled Small Business Employee Benefits. A third is in the process of being thoroughly analyzed; however, the preliminary results are very interesting and are shared later in this statement. In addition, the rising cost of health insurance was the number one problem as first reported in NFIB's 1986 Small Business Problems and Priorities. It was also one of the top concerns raised by the 1986 White House Conference on Small Business.

MANDATE Results

NFIB constantly polls its membership. No position on legislation is taken without approval of a majority of the membership. On the issue of health insurance and health care, small business owners have been loudly registering their concern over the focus of the debate. Mandates, massive expansion of federal government programs, national health insurance, or Canadian system mimicry ignore and exacerbate the real problem for small business--rising health insurance costs.

In April 1987 an overwhelming 89% opposed mandated health insurance (7% favor, 4% undecided). In 1989 small business owners again registered their overwhelming opposition to mandated health insurance legislation.

A consistent finding of our research is that the number one problem facing small businesses is the cost of health insurance. This conclusion was evident in 1986 when out of seventy-five issues polled (from taxes to unemployment compensation to utility rates), the cost of health insurance ranked number one -- even above liability insurance, which was at that time in a crisis state. The problem with the cost of health insurance continues to remain at the top in 1989. In fact, in the newest NFIB comprehensive health study, an astonishing 89% listed health insurance as becoming prohibitively expensive.

Small Business and Health Insurance

The 1986 survey by the NFIB Foundation, entitled Small Business Employee Benefits, revealed that the number of small business owners providing employee health insurance had steadily increased since 1978. The 1989 survey reveals that coverage has since stabilized.

In 1989, as in 1986, sixty-five percent of small businesses offered health insurance for at least some full-time employees. Increases in the coverage rate since 1978 have been most notable in firms involved in financial services, professional services, retail, and the smaller firms -- the very same firms held responsible for the alleged increase in the uninsured population. The troubled, and difficult to

insure, agricultural sector continues to be the only sector that reduced coverage. NFIB field survey data from April, 1987 indicate as many as seventy-five percent of those providing fringe benefits are providing health insurance. This is despite the fact that in 1985, the median monthly health insurance premium paid by small employers was more than double the premium in 1978.

Small businesses tend to offer a hierarchy of benefits which expands as the firm matures and size increases. Small business owners as a group provide their employees with a wide variety of benefits, paid vacations and health insurance being the two most commonly offered. In addition, larger small firms are most likely to provide a wider selection of benefits to a larger number of employees than are the smallest firms.

Well over 80% of the health insurance plans offered in small firms carried an option for dependent coverage; however, fewer part-time employees were offered coverage and usually only after a vesting period with the firm. Yet, the majority of small firms offering coverage paid 100% of the premium costs, in sharp contrast to their larger counterparts.

No single reason dominates a small firm's decision not to offer health benefits. The most frequently cited reasons for not providing health care coverage to all employees were: premium expense, employee turnover too great, generally covered under a spouse or parent policy (secondary wage earners), firm insufficiently profitable, and cannot qualify for a group policy. The latter two received the heaviest response rate in the 1989 study.

Small Business in 1989: Preliminary Survey Results

In 1986, NFIB first identified the cost of health insurance as the number one problem facing small business. When asked in 1989 whether the "cost of health insurance is a serious business problem," 66% strongly agreed and 26% agreed with that statement. In addition, 89% found health insurance becoming prohibitively expensive, and respondents offering health insurance had seen increases in premiums in the past year.

Contrast the above to some of the attitudes held by small business owners. First, 71% believe that every American has a right to basic health care, and 74% believe that Americans should receive a minimum level of health care, regardless of their ability to pay. It is at this juncture, however, that small business owners part company with many policymakers in Congress. Small business owners do not support mandated health benefits for businesses or even those directed at individual purchasers. They also do not support raising taxes to increase access to health care for low income individuals, much less for the 38% of uninsured individuals who reside in households earning $20,000 or more a year. Since 1978, a consistent finding has been that small business owners believe individuals have the first responsibility to see that they have health insurance coverage.

The cost of health insurance is posing a dilemma for small firms. Many believe that increasing costs are (or will) make it difficult to compete, and only a minority believe that such costs can be fully passed on to the consumer. Small firms are also discovering that employees prefer wage increases to benefit increases. The younger or more part time the firm's workforce, the greater that preference. In addition, the majority of small business owners do not believe that they have lost good or potentially good employees because of inadequate health benefits. These mixed signals coupled with dramatically increasing costs and low business profitability (over 40% reported that they could earn more working for someone else) do not bear out much hope for encouraging small firms who do not currently offer insurance to do so. Market pressures and employee preferences do not appear to be driving forces in the current debate.

Preliminary analysis of the 1989 survey has raised two interesting features of the small business health insurance market. First, most small business owners do not believe that insurers aggressively compete for their business. Second, of those who do not offer coverage, many independently responded that they were "too small" to get coverage. As in the past, it appears that small firms remain the stepchildren of the insurance industry. High overhead and marketing costs make the small business sector an undesirable target. It is also difficult to fashion cost containment packages for small firms because of the unique dynamics of a small company such as adverse selection, employee turnover, and inability to self insure.

Any downturn in the economy will also have a significant impact on the availability of health insurance as a fringe benefit. Our data strongly suggest that the offering and/or "richness" of this fringe benefit is directly related to business profitability.

Clearly, the policy solution lies with incentives--for both individuals and for small firms unable to afford coverage. Sixty-two percent of small business owners support the government taking a more direct role in bringing health costs under control. Incentives may be the key to unlocking the problem of premium costs, the problem of health care costs lies elsewhere.

Small Firms and Unaffordable Health Insurance

Providing health insurance is much more costly to small firms than to their larger counterparts. By their very nature, small firms are labor intensive and employ many part-time employees. In addition, most small business owners have lower median incomes than wage and salary earners. Clearly, the fat has been trimmed.

Several external factors enter into the equation in determining insurance coverage. First and foremost, small firms are generally unable to self-insure, thus they are forced to operate under the ruberic of costly state health insurance mandates. While discussed later in this statement, state health insurance mandates drive up the cost of health insurance for firms that purchase in the open marketplace and preclude the offering of "barebones" insurance policies. The lack of affordable "barebones" catastrophic insurance keeps both small firms and individuals out of the market.

Second, according to recent Health Insurance Association of America (HIAA) estimates for 1988, premiums in small firms run 15 to 25 percent higher than those of large non-self-insured firms. The Small Business Administration estimates that administrative costs for small firms can be as much as 40% higher than their larger counterparts.

Third, more than two-thirds pay the entire premium, and a whopping 87% pay more than half. In addition, small employers are more generous than large employers when family plans are offered. According to the Small Business Administration, of those firms offering family health insurance plans, 70 percent of the very small firms (1-9) and 55 percent of 10-24 employee firms, but only 34-35 percent of larger firms, pay the entire premium for family coverage.

Fourth, the cost/benefit ratio for small firms is also skewed against small firms. Of each $100 paid in premiums, small firms derive only $75 in benefits, whereas large firms receive $95 (Nexon, 1987). The reasons for such a differential in both the benefits ratio and higher premium costs include: lack of economies of scale, cost of administration, insurer fear of adverse risk selection, instability in the firm, and the lack of expert help in selecting insurance plans.

Fifth, HMOs and managed care systems are not aggressively marketed to the small business sector for many of the reasons outlined above and because small firms tend to be very traditional in their choice of health care providers. Thus marketing requires a greater basic educational level. Compounding the problem is a plethora of state laws restricting HMOs.

The problem of the start up, marginal and "high risk occupation" firms are also important factors in determining the ability to obtain health insurance. Underwriting practices routinely exclude these firms or refuse to offer "discount" group rates.

A Solution: Cost Containment, Development of Incentives and Removal of Barriers

As mentioned previously, the system of incentives has worked. This Committee should consider expanding the incentive approach in the following fashion:

1. The tax laws give a distinct advantage to the business owner who operates in the corporate form as opposed to the business owner who operates as a sole proprietor or partner. In the corporate form, the owner's full health insurance costs, as well as those of his employees, are deductible as business expenses, while for the self-employed, only the health insurance costs attributable to the employees are fully deductible.

The Tax Reform Act of 1986 made a move in the right direction by allowing 25 percent of the cost of the self-employed business owner's health insurance costs to be deductible. However, this partial, and now targetted for extinction, deduction denies the self-employed business owner the incentives given to the corporate business owner to obtain health insurance from him/her and the firm's employees.

According to a 1985 study by the Employment Benefits Research Institute (EBRI), 22.4 percent of self-employed business owners carry no health insurance. These business owners make up between six and sixteen percent of all uninsured workers. Full deductibility, therefore, would address a significant portion of the health insurance gap that exists simply by equalizing the treatment for incorporated and unincorporated businesses.

2. Provide a tax deduction or credit for individuals to purchase their own health insurance. The credit/deduction should be targetted to low income families with children. While access to health care has developed into a right, it is not the obligation of the employer to ensure that right. Rather individuals, attached or not attached to the workforce, should be provided with assistance in affording the purchase of health insurance. The deduction should be limited to premium assistance and be available regardless of whether a taxpayer itemizes or meets a threshold.

3. Allow for a partial refundable tax credit or payroll tax credit for the cost of the benefit for small employers who provide health insurance. This type of deduction would be targetted towards the sizable number of small firms who do not have taxable income and hence are unable to take advantage of the current deduction.

In addition, a whole range of other problems occurs with the disincentives currently in place in the law. Appendix 1 illustrates this point.

1. State health insurance mandates. Clearly, the most troublesome disincentives is the cost of health insurance and health care. One relatively simple way to lower health insurance costs is to preempt state health insurance mandates. State mandates for specific types of benefit coverage now number over 690. These state mandates have seldom surfaced as a result of constituent demand,

but rather have been initiated by well-organized special interest groups, including the providers of services themselves. State mandates range from coverage of wigs (MN) to herbal medicine (FL) to in vitro fertilization (proposed-OH) to special diets for people with Crohn's disease (Mass). Together, they preclude the offering of "barebones" affordable policies for non self-insured companies--the majority of whom are small businesses.

The end result of benefit mandates has been a remarkable growth in the number of providers performing the mandated service -- providers who suddenly find that payment for all services is available, indeed mandated, by state law. In Wisconsin, the passage of a mental health mandate resulted in a phenomenal rate of growth in the number of outpatient mental health clinics -- from less than 40 to more than 900 in ten years. A similar mandate is contained in S. 768.

In Maryland, state mandated insurance benefits were estimated to raise the combined average cost of group and individual Blue Cross/Blue Shield coverage by more than 11% in 1984; outpatient mental health benefits alone were estimated to raise total plan costs by more than 4%. Current estimates tag that increase near 20%. Mandates eliminate the cost control mechanisms provided by comparative choice and increase the cost of health services.

Benefit mandates make coverage prohibitively expensive due to the legislative dictates of the package's components. They take away the right of the insurance purchaser to select and pay for coverages based on the needs of the workforce and the ability to pay. Buyers end up spending scarce resources on benefits that they may not want or use, or reducing coverage for more essential health services in order to accommodate the extra costs associated with mandates. S. 768 with its "well baby" and "mental health" provisions is headed down this costly path.

2. COBRA. At a minimum, reform of COBRA is also necessary. Simple changes, such as requiring election of continued coverage two weeks after termination of employment, increasing the administrative fee to reflect actual costs, changing of dependent coverage requirements to preserve the status quo rather than providing an independent right to enhanced coverage, and quarterly advance payments would go a long way to helping relieve some of the costly burdens COBRA has placed on small firms.

3. Costs. All involved in the health care field bear some responsibility for the escalating costs, including individuals who are no longer purchasers, but simply middlemen between the health care provider and the insurance carrier. Active consumer participation is necessary to control costs and regulate service usage. In addition, the issue of the burden of uncompensated care in non-profit hospitals must be balanced against the billions of dollars of foregone local,

state, and federal tax revenue. This forgiven tax burden is borne by the rest of the business community. In return for such enormous tax relief, hospitals have willingly entered into social compact to provide charity care and that obligation should not be assumed by the federal government.

Protocols and liability/malpractice tort reforms should also be examined as part of the solution to drive down the cost of health care. Cost containment is the cure for the disease of limited access to quality health care. With effective cost containment, the symptom of the uninsured will be treated.

Conclusion

There are ways to encourage the expansion of health insurance coverage to employees of small firms, other than mandating coverage. A better alternative is to put small business on a footing more equal with their larger competitors -- equalize the health insurance premium deduction for the self-employed business owner, provide equal protection from state benefit mandates, explore the development of workable incentives to small firms--including expanded tax incentives, and remove government-erected disincentives to providing coverage.

Much of the problem, though, is structural. First, we have just been through a period of record numbers of new business startups. Those marginal firms coupled with firms that leave the marketplace make up a significant portion of the small business community, roughly 20% at any given time, who are unable financially to provide significant fringe benefit packages or unable to obtain coverage because of their insufficient or nonexistent experience rating.

Second, the data we have indicate small employers provide health insurance benefits when they are financially able. Small firms are responding to workforce pressures to provide benefits comparable to large corporations. The small firm, however, must be given the flexibility to phase in those benefits as the firm matures, becomes more profitable, and as the employees demand such benefits.

I would reiterate that small employers continue to offer health insurance, but it must be kept affordable in order for small firms to retain and expand coverage. Small firms are one of the true victims of the health care cost crisis. The paternal instinct to provide for their employees is alive and well, however, many small firms are precluded from acting on it because of the costs of health insurance.

Attachment

Testimony of Teresa Matregrano

Before: National Advisory Council on Social Security

Date: Thursday, September 27, 1990

Subject: Mandated Health Insurance, Small Business, and the Market Place

Good morning, my name is Teresa Matregrano. I am speaking as a small, independent business person who has owned and operated several small businesses over the last 20 years. I currently own Blue Star Glass, a full service commercial glazing house in Hudson, New Hampshire.

I am here as a small business owner and member of the National Federation of Independent Business (NFIB). I have been asked to address the Council's mandate to assess the national health care crisis and how it may be solved. At the outset, I would like to state that requiring private enterprise to provide health insurance is not the appropriate way to solve this crisis.

Introduction:

In an attempt to clarify our position, it often becomes necessary to define what we are to better understand who we are. In my community alone, small business represents hundreds of business establishments and thousands of jobs. My business employs 11 people.

The National Federation of Independent Business represents over 540,000 small business owners throughout the United States. NFIB derives its policy positions from the MANDATE, a poll distributed to all members on a bimonthly basis, and through surveys and research conducted by the NFIB Foundation. The NFIB Foundation has conducted three comprehensive surveys on health benefits. This data spans more than a decade of immense growth in the community and dramatic increases in the cost of health care and insurance.

The average NFIB member has less than 13 employees and gross revenues of less than $250,000 per year -- or less than $30,000 a year as income for its owner. It appears that the average increase exceeds the national average of approximately 20% (HIAA, 1989). In fact, since 1986 the cost of health insurance has been identified as the single most important problem faced by small business owners. Small business owners currently providing health insurance are faced with higher premiums and the lack of availability of alternatives in the marketplace. Those not providing coverage report that they are unable to locate an affordable policy or that coverage at its current inflated price is simply beyond the means of the business. These business owners and their employees are left bare in a world where one accident could bankrupt the business or the family without the insurance as a buffer. In spite of these costly barriers to providing health insurance, NFIB members remain opposed to mandated benefits. It's the strongly held belief among American small business owners that mandated health insurance benefits will put their business on a cost rollercoaster that could bankrupt their businesses.

Collectively, small business owners are eager to enter the marketplace with our trade, service or product and our determination to build a better mousetrap. Often under capitalized, some of us attempted to traverse the maze of the SBA only to complete the route unqualified or lacking available funds. Private lending institutions listened carefully, offered encouragement and then requested that we come back in a year or two. Determined and independent, we borrowed from family and friends, mortgaged what we had, and opened our doors, in spite of this lack of so called professional help.

Although many fledgling companies cannot offer the big "benefit packages" to prospective employees, their employees still accepted positions with a look to their own futures and an understanding of the inherent fairness and family atmosphere within these businesses.

Blue Star Glass's Experience:

I have operated my current business since 1982. It took me five years before I was fiscally able to purchase a health plan for my employees. In 1987 the cost of that plan was $190.00 per month per family; in 1988 $275.00; in 1989 it was $376.00. In 1990 it jumped to $496.00 per month per family. During this time period we also felt the burden of rising Social Security taxes, unemployment insurance premiums and a host of other payroll taxes. Most dramatic of all the increases was Worker's Compensation insurance. In 1982 we paid $1,900.00 per year, this year we will pay almost $15,000.00 - a figure that includes a discount factor for 'good behavior'. Combined, these fixed costs continue to grow at an equal or greater rate relative to my company's sales.

In March of 1990 we went in search of a new health insurance carrier, one that we might be better able to afford. Because my company has no benefit administrator, I undertook to learn and analyze the various plans myself. Like other small business owners, I found the process of selecting an affordable plan that would protect my employees and was affordable to be very time consuming and complex. After three months of studying policies we were able to cut cost by 15 percent. However, the insurance company would only write the policy for SIX MONTHS. In September of this year, we were forced to tell our employees that they would have to pick up half of the cost of that insurance because of the __% increase in premium costs. I hope that the time does not come that the cost of those premiums forces me to drop coverage all together.

My story is not unusual. Small business owners in New Hampshire and throughout the country are facing big increases in health insurance premiums. If health insurance was mandated at this time, I would have no other option but to lay people off or to close my doors. Mandated benefits raises several concerns including the impact on job creation, business expansion, and the curtailment of small business start up.

The independent business person is inherently dictated to by his/her own ethics to be fair. We understand the value of our own hard work and, for the most part, are more than willing to reward that same ethic in our employees. That ethic is the backbone of a kinder, gentler America, but is surely one that should not and cannot be mandated.

SUBMITTED
STATEMENT OF
GERRY HARKINS

Before: The National Advisory Council on Social Security

Subject: Mandated Health Insurance

Date: January 31, 1991 in Atlanta, Georgia

Good evening, my name is Gerry Harkins. I am the owner of Southern Pan Services Company (Conley, Georgia) and a member of the Guardian Advisory Council of the National Federation of Independent Business (NFIB). My company is the employer of 150 to 500 people in commercial construction in Georgia and Florida. Our work force is comprised of a core of permanent employees, numbering approximately 100, and a larger number of temporary employees typically hired for a specific project lasting 6 to 12 months. The core of permanent employees is comprised of 50 key management employees and 50 rank and file employees. Labor comprises 70% of our cost of doing business. Our 1990 taxable income was near $500,000.

Management employees are given fully paid health insurance as a benefit, which is essential for attracting and keeping good managers. The cost of this benefit has grown at a rate of 40% per year over the last two years and averages $100 per week/$400 per month. If there are any ascertainable health risks, coverage is unobtainable. In the past, the insurance carrier has refused to cover certain employees because of their health conditions or have imposed a twelve month pre-existing condition exemption before covering them. In that case, I have purchased individual policies, at a higher cost for fewer benefits, in order to ensure that they have health insurance. There is not much an employer can do in such a case -- a good employee who later gets sick is still a good employee. We have decided to continue to provide him or her with insurance, even though its at the risk of higher premiums for our other employees.

We presently offer health insurance to our rank and file employees, but we cannot afford to subsidize the premiums. Premiums are approximately $40 per week/$160 per month for single coverage and approximately $55 per week/$220 per month for family coverage, if the employee and his dependents are healthy. These premiums are slightly less than those of the management employees because of the bad experience rating, due to several illnesses, of the management group. Because our insurance group is made up of healthy and unhealthy individuals, the premiums are too high for most of these employees to pay and many do not elect coverage.

The large group of temporary employees are also offered insurance after they have been employed for 90 days, but again neither they nor we can afford to pay the premiums. This group is paid an average wage of $7.50 per hour. In order to afford that coverage these employees would essentially have to forego $1.37 per hour, which is much too high to be an incentive to purchase the insurance.

Health insurance is now our third largest payroll related expenditure, behind workers' compensation and general liability insurance. At its present rate of increase, health insurance may soon move into second place behind workers compensation.

Health care costs are increasing at a rate that is far greater than the growth in our economy. Costs are becoming prohibitive and will become worse as we move deeper into a recession. In the highly competitive construction industry where companies are chasing fewer and fewer projects, we are not able to pass these increased costs to our customers. Thus we must absorb them, ask the employee to pay, or cease operations. The need for increased availability of health insurance and affordability of health care is great. Our employees are our greatest resource and their health is a concern that we share with them. Unfortunately, we would not be able to employ them if we added the cost of health insurance to their wage base. What can be done to solve this "Catch 22 situation"?

There are some senators and congressmen in Washington who advocate mandated health insurance to require the employer to provide health insurance for all his employees. Presently for every dollar of gross payroll we pay another $0.20 in mandated payroll costs. These mandated costs are comprised of matching FICA, state and federal unemployment insurance, and workers' compensation insurance. These are also rising at an alarming rate.

Let me illustrate the effect of proposed mandate on my business. Assuming, as mandated health insurance proponents do, that the mandated coverage would cost only $1,250 per year for a single coverage and $2,500 per year for family coverage, my annual cost would be increased by more than $500,000. This represents the company's entire taxable income. Without a profit, I have no incentive to take the risk of doing business nor any capital with which to do it. I fear that this scenario would be played out in thousands of small businesses throughout the nation, causing millions to be unemployed, and deepening the recession.

In 1989, the Georgia legislature created a 29 - member commission to study health care problems and to recommend solutions. The results of this effort have recently been published and I hope that they have been or will be presented to this Council. Their recommendations include broad based funding of a high risk pool to cover those who cannot obtain health insurance coverage in the private market, the implementation of which should significantly reduce the cost to other group members. Group health

insurance was initially designed to reduce the overall cost of health insurance to its members by spreading health risks over a large group, now it can result in increased costs for all members of a group that contains one or more employees or dependents who have, over their term of employment, developed a health problem.

Another recommendation would encourage insurers to offer a basic, "bare bones" or "essential care" (free from costly state heath insurance mandates and special medical care provisions) that would cover basic medical treatment with reasonable deductible and co-insurance. Based upon my experience, to encourage participation this policy would have to be no more that $0.50 per hour for single coverage and $1.00 per hour for family coverage. To further help encourage employer subsidies, small employers should be offered tax credits in the amount of their contribution on behalf of the employee to either the premium, the deductible or the co-insurance payments.

The commission also recommended that laws be changed to make Preferred Provider Organizations more competitive and to allow insurers to establish exclusive provider organizations. I believe that Health Maintenance Organizations should also be encouraged to expand their markets, and to expand into the small business marketplace with essential care policies -- something federally qualified HMOs would be unable to do.

As an employer in a labor intensive industry, I am being crushed between the need for and the availability of affordable health care. There can be no quick fix, only a slow cure brought about by careful study followed by patient and resolute action. I urge you to pursue that slow cure approach and reject the simple, quick fix mandate approach. Mandates will devastate my industry because they would drive up personnel cost by imposing a tax on employment. I know my company's future would be put in jeopardy with a mandate as would many other small businesses here in Georgia and nationwide.

Thank you for the opportunity to be heard.

Testimony of Rod Starkey
Pacific Messenger Service
San Diego, California

BEFORE: National Advisory Council on Social Security
Field Hearing, San Diego

DATE: February 14, 1991

Good morning. My name is Rod Starkey. I am the President of Pacific Messenger Service. Pacific Messenger Service is a family-owned and operated business founded in 1910. We are a parcel delivery service operating throughout the southern California region. We employ 65 full-time workers. We provide health coverage through two HMO's located in San Diego and Anaheim.

About four years ago, Pacific Messenger Service switched from a PPO traditional insurance plan to an HMO plan because of the high costs of the PPO plan. Until just a few years ago, Pacific Messenger Service offered and paid 100% of the cost of health insurance for the employee's personal coverage. The employee was responsible for the cost of dependent and spousal coverage. Because of premium increases averaging 20 to 25% each year, we have revised our policy and now will pay the first $100.00 in premium costs for the employee's coverage. All employees are eligible to

participate, some elect not to take coverage either because of the premium sharing or because they are covered under another plan through a spouse or parent.

My current premiums are as follows:

San Diego office	Anaheim office
$119.78 per employee	$108.84 per employee
$239.36 for spousal coverage	$217.68 employee and spouse
$347.36 with two or more dependents	$308.24 two or more dependents

In 1990, Pacific Messenger Service paid $53,534.00 for health insurance coverage with the balance of insurance premiums paid by our employees. I fully expect costs yo my employees to increase again this year by another 20 to 25%, for reasons unknown to me. I suspect that the charges levied upon insurers and HMOs by MedCal are partially to blame.

Like so many other NFIB small business owners, the number one expense Pacific Messenger Service faces is the cost of insurance. We operate a labor intensive service business which makes fringe benefit costs very expensive. Last year over $500,000 was spent on insurance costs -- health, liability, workers compensation, and miscellaneous insurance like vehicle coverage. This amount

continues to climb and climb and climb each and every year. Insurance costs eat away over 8% of our gross revenues. To give you another example, today Pacific Messenger Service spends $17.62 for every $100.00 in salary for workers compensation for a total of $140,000 last year.

With these skyrocketing costs, particularly costs like health insurance that are discretionary costs, it is becoming harder and harder to compete against the huge, national parcel service companies. I cannot raise my rates 20 to 25% each year to cover the health insurance increases. If I did, I would lose my customers to the big companies and eventually go out of business. In fact, in California today Pacific Messenger Service is one of the only mid-sized parcel service companies still left. The market is now dominated by the big, national companies and the very small mom-and-pop four truck companies where ten years ago there were hundreds of firms of all sizes. The mid-sized firms have simply been squeezed out of existence.

I strongly oppose mandating health insurance provision by employers. Imposing that kind of cost upon us would reduce the market to just the national companies -- they would be the only ones able to afford that type of an enormous burden. The rest of us would either go out of business, lay-off employees, or become an independent contractor operation in order to avoid the costly impact such a mandate would have.

I believe that the solution lies with reducing the cost of insurance and the cost of health care. Something must be done to stop these huge yearly increases. Pacific Messenger Service cannot continue to compete with our costs rising so rapidly and our employees may not be able to, or want to, continue to shoulder the increased premium costs. Frankly, I suspect that many of my workers -- particularly those who are young and healthy -- would prefer to have money in their pockets rather than health insurance.

I urge you to look for the solution that lowers these costs and keeps mid-sized and smaller businesses in business.

Thank you for the opportunity to testify before you today.

Testimony of Eddie L. Mills

Before: National Advisory Council on Social Security

Date: Wednesday, March 27, 1991

Place: Sunshine Center: St. Petersburg, Florida

Subject: Mandated Health Insurance in Workplace and its Effects on Small Business

My name is Eddie Mills. I am President and Senior Partner of Mills-Anderson Opticians, Inc. We own and operate three retail optical outlets in St. Petersburg and the vicinity. Currently, we have 6 employees.

I am here today representing myself as a small independent business owner. But I am also speaking for the thousands of small and independent business owners throughout our nation who are facing a crisis in providing employee health insurance.

Wherever I travel -- Washington, Atlanta, Dallas, Tallahassee -- I hear the same message: employee health insurance costs are rising at an inflationary rate. In my own company, the increase averaged 25% per year from 1980 to 1990. In two of those years the increase was 40%.

I do not support mandated health insurance. A mandated health insurance program can only lead to further premium increases, and ultimately, to bankruptcy for many small business firms. The nation's economy, already in a tailspin, will be adversely affected. Not long ago the small business community accounted for 85% of non-personal tax revenue. Today, it is below 65% and declining at an alarming rate. Small wonder that federal deficit can not be reduced. Mandated benefits will only further harm the small business community.

What then is the solution to this national problem? Let me suggest to you some possibilities and request that you also consider others that would create competition in the insurance and medical services market places.

1) Professional liability premiums are so high they are forcing many health care providers to increase annually their fees for service. We need to search for ways to reduce this spiraling cost. One method would be to limit the non-economic damages in malpractice lawsuits and to allow those damages to be offset by insurance payments. Another would be to limit the time a plaintiff has to file for recovery, resulting in reduced attorneys fees. Still another is to encourage and strengthen the arbitration process and possibly to make it binding.

6) Focus upon affordability. For example, we currently pay matching FICA taxes on salaries up to 53,400 dollars. We often hear the phrase "The rich get richer and the poor get poorer". No further proof of this is needed than a quick look at the FICA formula and its payment schedules. But is also hurts the low and middle income small business owners through the matching tax. I suggest to you a formula whereby FICA taxes would be lowered to 6% on 40,000 dollars, then exempt the next 60,000 dollars, and then be taxed on all wages above 100,000 dollars. This would allow many small business owners to retain enough profit to afford an equitable health insurance plan for their employees.

7) Ensure that very small businesses can purchase health insurance at truly group rates. There is no reason that small businesses should be rated and priced differently from their larger counterparts.

It will be a gross injustice to the small business community, and to the Nation's economy, to enact any comprehensive changes like national health insurance or mandates without considering the financial impact on small employers and without searching long and hard for affordable alternatives.

I appreciate your indulgence, and I hope you will give these recommendations serious consideration.

I thank you for this opportunity to appear before you today.

BY: Donald F. Summers, Austin Welder and Generator Service

BEFORE: House Ways and Means Subcommittee on Health

DATE: Thursday, May 2, 1991

SUBJECT: Health Care Costs and Lack of Access

My name is Don Summers. Thank you very much for the honor and privilege of speaking to you today. I have come to speak to you on behalf of my business, my family and the 500,000 other members of the National Federation of Independent Business regarding the health insurance crisis. The health care crisis influences the continuing operation of all small, family-owned businesses.

Our company, Austin Welder and Generator Service, in Austin, Texas, was started in 1978 by myself and my oldest son. In December of 1978, we were joined by my second son. Our company specializes in the maintenance and repair of electric welding equipment and power generating systems such as emergency back up generators at hospitals and large office buildings.

We currently have nine full-time employees, including family members. We have no part-time employees.

When we started the company in 1978, our gross income was $16,500. In 1990, our gross income had increased to $610,000, and our payroll was approximately $210,000. Our year end net profit was 1.54% or approximately $9,400.

Since first opening our business, we have felt a very strong moral as well as business obligation to provide quality health insurance for our employees. We began providing that benefit in about 1980, offering health insurance for employees and their families. The cost of this insurance was paid entirely by my company.

Between 1980 and 1990, my business had four different health insurance plans. Under each one, costs became so prohibitive that I was forced to search for a less expensive plan that still provided good coverage.

In 1990 we had to make an extremely difficult decision. In May of that year, the cost of our health insurance had increased to the point that it exceeded our monthly profit after all other expenses had been paid. Despite the increases, our company continued to provide coverage but with a higher deductible. Even by increasing that deductible from $300 to $600, we still found the cost of the policy too prohibitive for our company and for our employees.

During that time, our accountant and I spent a great amount of time searching for more affordable coverage. Personally, I have trouble enough keeping up with the advances and changes in our own industry. None of us in our company has the time to become an expert on health insurance. So we must depend on the integrity of an agent or other insurance industry representative to help us make the right choice.

In addition to pursuing higher deductible plans, we looked at other standard plans and HMOs as possible ways to reduce the cost of health insurance to our company. However, our carrier had explained that for companies in our size group, costs were escalating.

Finally, frustrated and saddened, we had no choice but to cancel our coverage and announce to our employees that as of September 1, 1990, they would have no health insurance. That was, without doubt, the most painful announcement that I have ever had to make. To the best of my knowledge, none of our employees has since acquired health insurance on their own.

In a small business, a good health insurance plan not only reduces the strain and worry on the part of the employee. It also allows us, the employer, to hire better trained, more professional employees. It upsets me not to be able to afford to provide coverage to my employees.

I believe that state health care mandates are a major contributing factor to the increased cost of coverage. In Texas, no basic health plan exists that will allow an employer to purchase a basic health care package. By "basic health care," I mean a policy that might not cover minor illnesses like a cold or sore throat, or other non-life threatening illnesses, but one that would gain access to doctor or hospital care for the more serious illnesses.

A federal mandate requiring small businesses to provide health insurance would, without any doubt, lead to the reduction in size or closure of many businesses. I am convinced that even if the rates for mandated plans were low at the onset, they would soon increase to the point of being too expensive because of medical cost inflation.

The small business is the heart and soul of America. Many of us, as owner/operators of small businesses, are in "face to face" contact with all of our employees every day, and are therefore intimately aware of family health problems. It deeply troubles me to hear of someone needing health care and not getting it because it is too expensive.

Please, gentlemen, help me, other business owners and our employees find basic health insurance packages that are affordable.

Before I close I would like to submit for the record five other statements by small businesses owners from around the country. I was struck by how similar our problems are -- we are all caught in a conflict between our values and the prohibitive cost of health insurance.

Thank you very much for today's opportunity to tell you my story.

STATEMENT SUMMARY
Donald F. Summers, Austin Welder and Generator Service
April 9, 1991

My name is Donald F. Summers, owner of Austin Welder and Generator Service in Austin, Texas. I started my company with my son in 1978. We currently have nine full-time employees, including my second son.

By 1980, our company was able to provide health insurance for our employees, paying 100% of the premium. We did so because we felt we had a moral obligation to provide quality health insurance for our employees.

Over a period of ten years, we were forced to change plans four times because the rates became prohibitively expensive.

In 1990, we had to make an extremely difficult choice. The cost of our health insurance had increased to the point where it exceeded our monthly profit after all other expenses were paid.

None of us in our company are health insurance experts. Shopping for quality packages is difficult and time-consuming. However, in order to try to find a solution, our accountant and I searched for other options, including looking at other types of standard plans, plans with higher deductibles and HMOs in order to keep costs down.

Finally, we were forced to cancel our health insurance for our employees. It was the most painful announcement that I have ever had to make.

State mandates are a contributing factor to the increased cost of coverage. In Texas, no basic plan exists that would allow an employer to purchase a basic health care package -- one that might not cover minor illnesses but would provide coverage for more serious illnesses.

A federal mandate would, without any doubt, lead to the reduction in size or closure of many businesses. Even if prices were low at the onset, medical cost inflation would send prices skyrocketing in a short time.

Small businesses are the heart and soul of America. Small employers know their employees "face to face" and want them to have health care coverage.

Please, gentlemen, help me, other business owners and our employees find basic health insurance packages that are affordable.

Thank you for this opportunity to tell you my story.

PREPARED STATEMENT OF SALVATORE A. RISALVATO, RIVERDALE SUNOCO, RIVERDALE, NJ; BEFORE THE SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES (JUNE 11, 1991)

Good morning Senator Kennedy and members of this distinguished Committee. I would like to thank Senators Hatch and Kennedy for extending an invitation to appear before you so that I may explain the position of the small business community on the topic of mandated health care.

I would like to start by saying that I am a small business owner and that I employ 10 people. I have been in business for over 16 years, and have never been employed by anyone other than myself. For the past 14 years, I have been in the auto repair and gasoline business.

Since 1980, I have been a proud and active member of the National Federation of Independent Business (NFIB). I am here this morning to speak on behalf of the 500,000 members that belong to NFIB and who voice their opinion through the NFIB MANDATE ballot. I am also an active member of the New Jersey Gasoline Retailers Association, and serve as Vice-President of the Riverdale Business Association in my community. I was elected in 1986 as a delegate to the White House Conference on Small Business from my home state of New Jersey. In short, I am a staunch supporter of the free enterprise system, and a true believer that small business is the foundation that this country is built on.

Obviously, our nation is facing some pretty tough decisions regarding the availability of health insurance. I applaud you, Mr. Chairman, for recognizing this critical issue and commend you in your efforts to get a national discussion started.

To say that "the problem with our health care system is that not enough Americans are covered by health insurance" is incorrect. The fact that so many Americans do not have insurance is not the problem, it is the result. The problem lies in the outrageous cost of health care and the reasons for that outrageous cost. I ask that you take a careful look at the reasons health care services cost so much and to come up with a solution to reform the cost side of the system before you break the backs of the driving force of our nation's economy, the small business person.

I, myself, have provided health coverage for my full-time employees for the past ten years. When I first started to provide coverage, it was expensive but affordable. I was so happy and proud that I was providing benefits for my employees to protect them and their families. I remember wishing at the time that I could have done it sooner, but was still glowing that I finally had. I continued with the same carrier for the first five years, absorbing a few costly premium increases, but the sting was always unexpected, especially since other costs of doing business were not rising as fast.

The next five years were not so good. I have replaced insurance carriers three times in the past five years. Each time, on the anniversary of the policy, I received a notice that the rate for the upcoming year would be 40% higher than the previous year. Of course, rate hikes like that are simply not affordable, so I was forced to search for a new carrier each year, always cutting benefits, raising deductibles, and trimming the "frills" in order to make the premium more affordable. Some insurance carriers don't even have the patience to wait a full year, and will only guarantee their rates for six months. Each year for the past three years, I have had to carefully decide whether or not to change the percentage of our contribution toward health care or to even provide it at all. The obscene cost of continuing our policy of 100% contribution has been extremely difficult to maintain. One member of my local business community who employs 65 people has told me that he had the same health insurance carrier for 15 years before he too changed carriers three times in the past five years. He even had to hire a consultant to work through the different terms, conditions, and costs for each carrier so as to understand and properly select a new policy. The costs now have gotten so out of hand and unpredictable that he plans to pass any increases in premiums onto his employees. This situation is not uncommon.

While my business struggled to maintain it's policy, other small businesses were unable to afford health insurance at all. If reforms were started in motion to reduce the cost of health care then the cost of health insurance will also be reduced. Should the cost of health insurance be reduced, then certainly it will be more affordable to small businesses to provide it for their employees if, of course, they choose to do so. Also, if the cost of health care coverage were reduced to affordable levels, then more individuals would be able to purchase it for themselves. Of course, this is where the true responsibility lies -- with the individual.

Without exploring ways to dramatically cut the cost of health care, there will be no solution.

How can we start to cut the cost of health care? We can start by making a determination when we receive our hospital bill or a bill from a doctor, how much of the bill is a medical bill and how much is a legal bill. The ridiculous cost of medical malpractice insurance has two effects. First, it directly adds to the overhead of the doctor or hospital, and second, it creates an environment that encourages doctors to practice defensive medicine. Defensive medicine may include many extra tests and procedures to prevent a doctor or hospital from an

appearance of negligence. The absence of the appearance of negligence is needed to keep the sharks that we all know as attorneys from convincing gullible juries that their clients should become instant millionaires. I wonder if this is highly motivated by the monstrous fees generated from the settlement.

The second way of reducing costs is to promote consumerism in our health care and consumerism in health insurance. Since patients are really customers, they should be encouraged to behave like customers and shop like customers. In order to shop like customers, they need to know and understand the products and services that they receive from their doctors. This Committee should learn from consumer and medical experts just how this can be accomplished.

Last year my nephew was bitten by a squirrel. Nothing serious, it was an accident, the squirrel didn't mean any harm, he was only trying to steal a cookie that was in my nephew's hand and happened to catch a finger. A minor cut was the result. My brother, being a cautious parent and concerned about rabies, took my nephew to a nearby doctor. The doctor spent less than 3 minutes examining the finger, told my brother to put a bandaid on it, and billed him $50.00. That calculates out to $1000.00 per hour! That is not uncommon. Most people never ask the doctor how much his fees are, they just pay it.

Recently my sister-in-law, who is five months pregnant, was asked by her doctor to take a urine culture. Twice previously she was pregnant, and was treated by the same doctor without being asked to take a urine culture. Was this necessary? Or was this an example of profit taking? The doctor charged an additional $45.00 for the urine culture. The bill was submitted to the insurance carrier, so who cares? Right? A further check with another doctor found that his fee for the same urine culture was $15.00. It all makes you wonder what kind of excesses in costs really exist in the medical industry.

Consumerism in health insurance is just as needed and just as difficult to understand. Reforms should include a means to simplify and explain the differences between insurance policies. Consultants should not have to be hired to figure out the best policy for either an employer or an individual. Insurance companies market their products in such a confusing manner that it is difficult to compare apples with apples and oranges with oranges. We need to give the consumer a clear, simple, precise, plan of options. Don't give the consumer a policy that will nickel and dime you out of the hospital. There should be a commission set up to declare as many as 10 different plans, and each of those plans should be labeled plan A through J, and every

insurance company should be required to have the same frills for a plan A as all other insurance companies, and the same frills for a plan B as all other insurance companies, etc., etc. Then apples truly could be compared with apples, and oranges with oranges.

One other way to promote consumerism is to have individuals share more in the cost of health care. With higher deductibles and cost participation in any plan that an employer may provide, individuals will be more concerned about holding down costs. As a society we tend to be more mindful and prudent when we are paying the bills, and not very respectful when someone else is paying the bill. The free enterprise system will prevail here if given a chance.

The third avenue to explore cost cutting measures would be to review the health care requirements that each of the states impose on insurance companies that operate within their states. There are many non-emergency, non-critical expenses that insurance companies are required to cover if they offer health care coverage. Some simple examples are herbal medicine, in-vitro fertilization, and drug and alcohol therapy. There are many others, too many to list. Individuals and small business should have the option of choosing coverage in these areas in exchange for lower rates overall.

A fourth remedy for cost increases is the reduction of fraud in the medical system, particularly in Medicaid and Medicare. We have all seen the T.V. documentaries and news specials that reveal dishonest clinics, doctors, pharmacies, and pharmacists. As in any other business, there exists in the world of medicine those sleazy individuals who will choose to take advantage of the system. Experts should decide those sections of the system that are most abused, and suggest reforms that will work. Clinics, doctors and even patients that are caught abusing any insurance program, whether it be a private plan or a Medicare/Medicaid plan, should be severely punished.

The solution for our national dilemma is to allow the free enterprise system to function. Leave business alone -- stop mandating and regulating. Provide us with incentives, not punishments, and we will get the job done as we always get the job done. For two centuries businesses, large and small, have met their responsibilities and have inspired this great nation to grow.

The thing that bogs down growth and prosperity is government interference. The government has failed at having any prolonged success with any social welfare program, with the possible exception of Social Security, and it has been a hard fought battle to keep that solvent. The welfare system, food stamps, Medicare, and Medicaid have all

been rendered a failure. All of these programs started out with good intentions, but all have been so ravaged with inadequacies and abuses, that they are now an economic albatross to our nation. I shudder to think of the federal government in the health insurance business.

I also shudder to think of the same government telling me how to run my business. I put the key in the door every morning. I decide how much inventory our cash flow allows. I decide who should work what hours and for how much. I decide when a tool or piece of equipment is a good investment. I sign the check that pays the mortgage and the electric bill. Rest assured, Mr. Chairman, that the bank will call me if I cannot make my mortgage payment, and not the United States Senate. Therefore, Mr. Chairman, I should also decide what benefits and insurance I will or will not purchase.

If you continue to burden the small business community with more mandates and costs, you reduce the chances for our survival in an already fragile business environment. If small business is not able to survive, then both unemployment and inflation will rise, resulting in less revenue for the federal government and larger deficits than we presently have.

Small business will be happy to participate in finding solutions to this problem, but please keep in mind that small businesses did not cause this problem and small businesses should not be the ones that have to pay for it.

Thank you very much for allowing me to speak, and I will be happy to respond to any questions that you may have.

NFIB

National Federation of
Independent Business

June 13, 1991

Honorable Edward M. Kennedy
Chairman
Senate Committee on Labor
and Human Resources
SD-428 Dirksen Senate Office Bldg.
Washington, DC 20510-6300

Dear Mr. Chairman:

On behalf of the 500,000 small business owner/worker members of the National Federation of Independent Business, I respectfully request that this letter be submitted into the hearing record of June 11.

As this Committee is well aware, the number one problem facing small businesses is the rising cost of health care and insurance. It is costs, not coldheartedness, which limit the access small business owners, their families and employees have to insurance.

To help alleviate this problem for small businesses, individuals and the economy in general, NFIB has developed a detailed "Access for Small Business Strategy" which has been shared with this and other committees. This strategy takes direct aim at the root of our nation's health care problems -- medical inflation. Only through cost containment can we truly help those victimized by the present system -- the individual, the low income family and the small business. Only by focusing upon affordability will expanded access be achieved.

The introduction last week of legislation to mandate health insurance and raise payroll taxes is vehemently opposed by small business owners nationwide. When polled through the MANDATE ballot, over 96% opposed increasing payroll taxes to pay for the uninsured and over 90% oppose mandated health insurance.

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I would add one further reason for opposition to the "pay or play" proposal. It moves implementation of much needed help into the future. Small business owners and individuals need help today. Many of the proposals outlined in NFIB's "Access" plan are points of consensus achieved across a broad range of views and interests. Some are contained in the new Leadership proposal, many are cited by

The Guardian of
Small Business

members of this Committee, all could be enacted if the baggage of mandates, taxes or national health insurance were dropped. These points of consensus tackle the engine driving the problem of the uninsured or so-called underinsured -- rising costs. Until care and insurance are affordable, access will always to diminished or nonexistent.

Thank you for the opportunity to restate the NFIB position on health care reform and mandated benefits. As always, my staff and I are willing to discuss NFIB's plans for reform in detail with you and any other committee member.

Sincerely,

John J. Motley III
Vice President
Federal Governmental Relations

DESERT CONTRACTOR'S ASSOCIATION

June 17, 1991

"Regarding current health care and medical insurance, something must be done to ensure the availability and the affordability for those in this country. For many, health care and medical insurance costs are beyond reach. The small company under five employees have a very difficult if not an impossible time obtaining insurance."

James Jackson
President
Desert Contractor's Association

PREPARED STATEMENT OF CLARK C. HAVIGHURST

Mr. Chairman, I am Clark C. Havighurst. I teach and write in the field of health care law and policy at the Duke University School of Law. Much of my scholarship has been directed to discovering the reasons why the market for health services does not automatically allocate resources efficiently, as other markets generally do. Understanding why the market is performing badly may suggest policy moves that would improve the market's functioning, thus providing a policy alternative to the more sweeping reforms that are currently being proposed but that are politically difficult to accomplish and may fail to satisfy the American people. I continue to believe that, with correct incentives and public subsidies in place, with better information available, and with artificial constraints on consumer options lifted, the market for health care and health insurance could do a tolerable job of translating consumer preferences into efficient spending decisions by health care providers.

This hearing is concerned with the linkage between the high cost of state-of-the-art medical care and the accessibility of health services to all Americans. There is no question that the high cost of standard medical care greatly limits our ability to provide publicly for those citizens whose economic circumstances do not permit them to provide for themselves. Moreover, many Americans who could afford to purchase basic health coverage have been priced out of the market by the unavailability of low-cost options, thus adding to the number of uninsured Americans for whom some provision must be made. This committee has wisely noted the crucial connection between cost and access, and I welcome the chance to discuss this subject with you.

The focus of my testimony is the current state of the law affecting the purchasing of health care. My thesis is that the health care industry is currently subject to a seldom-recognized kind of overregulation that forecloses the offering and implementation of low-cost health care options that would otherwise be available to both public and private purchasers. If low-cost health plans were available, many citizens who are currently uninsured could, with appropriate subsidies provided through the tax laws, provide adequately for themselves. In addition, governments -- federal, state, and local -- could more readily discharge their responsibility to the remainder of the uninsured population at a reasonable cost to taxpayers. There are good reasons to identify and remove regulatory barriers to responsible economizing in the purchasing of health services.

The kind of overregulation to which I especially wish to

call the committee's attention is not the same regulation that many other commentators have blamed for the high cost of health coverage. I do not disagree, however, with these commentators' view that state laws prescribing the content of private health insurance policies -- so-called mandated-benefit laws -- are a serious problem. Ironically, large employers can escape the impact of these laws by self-insuring -- because of the federal preemption provisions in the Employee Retirement Income Security Act (ERISA). Such laws therefore raise the cost of coverage only for small businesses that do not have the option of self-insurance. It is precisely these employers that have failed in large numbers to extend coverage to their workers, adding to the large number of uninsured Americans. State insurance mandates are indeed a form of regulation that contributes to higher costs and reduced access.

Although I would support federal preemption of state legislation raising the cost of health insurance for small employers, I wish to direct my remarks today to a different and less widely appreciated kind of regulation, which also precludes responsible economizing not only by health care consumers and their agents but also by public programs for financing health care. The overregulation that concerns me is not statutory. Instead it is imposed by courts and the legal system through malpractice litigation and through lawsuits against third-party payers over coverage issues. By prescribing unrealistic legal duties for health care providers and unrealistic payment responsibilities for public and private health plans and by simultaneously threatening not to give effect to terms in private contracts specifying alternative obligations, courts have blocked some of the most promising avenues to economizing in the purchasing of health services. I wish to discuss this overregulation of American health care through the judicial system in these brief remarks. Although the problem of "defensive medicine" practiced under the compulsion of the law of medical malpractice has been widely noted and is part of the phenomenon I will discuss, the larger problem of judicial overregulation has rarely been identified with the clarity it deserves. In my view, the legal system is mindlessly forcing Americans to purchase either coverage entitling them to first-class state-of-the-art medical care or no coverage at all. To most of us, this is a Hobson's choice; to too many others, it means going bare in a potentially cruel world.

* * *

Overregulation of Medical Practice by the Judiciary

Since the late 1970s, public policy in the United States has placed increasing reliance on encouraging independent initiatives to contain health care costs. During the 1980s, costs in the private sector were treated almost exclusively as a private responsibility, while the states and the federal government

concentrated on controlling the costs of their own programs. Under this policy, both private and public health plans made significant progress in developing techniques for prudent, price-conscious purchasing and utilization management.

Despite the emergence of many new economizing techniques in recent years, however, a combination of circumstances and legal rules still inhibits public and private attempts to achieve efficiency in the use of resources for health care purposes. One crucial problem to which I wish to call the committee's particular attention is the limited utility of private contracts as instruments for specifying standards and rules to govern particular relationships between consumers, payers, and health care providers. Vital terms of these relationships are still prescribed, not by the parties themselves, but by the courts, borrowing standards wherever necessary from the medical profession. In litigation initiated by patients either against providers for malpractice or against payers to compel coverage for particular services, the legal system regularly gives professional norms and standards -- even ill-defined and poorly conceived ones -- virtually the same mandatory effect as public regulations. Because the law effectively precludes health care consumers from choosing to have their care governed by other standards, it effectively denies them many opportunities for responsible economizing.

Normally, of course, private contracts are the vehicles by which purchasers specify in advance the precise characteristics of the goods or services they are purchasing. As things now stand in the health care sector, however, consumers and their agents are unable as a practical matter to authorize providers to omit, and payers not to pay for, services that are of doubtful or only slight value -- if those services are seemingly mandated by professional standards. Most lawyers would predict that contracts varying the standard of care applicable to providers (or letting health plans off the hook for care that seems responsibly prescribed) would face rough going in the courts. To be sure, the problems that purchasers encounter are not only legal ones, because a different criterion to govern provider and payer obligations would be extremely difficult to define and apply in any event. Nevertheless, any effort to customize the standard of care to suit the parties' preferences and pocketbooks would also encounter serious legal obstacles. Specifically, there would be a significant risk of liability for every patient injury that a jury attributed to a physician's failure to render, or a payer's refusal to cover, care called for under professional norms.

The professional norms and standards that generally bind physicians and payers in the current legal environment are unsatisfactory from virtually every point of view. Because they are hopelessly vague and general, they induce physicians to

practice "defensive medicine," which may entail expenditures far beyond what the law would actually require. Payers may feel themselves bound to respect physician judgments even when significant questions might be raised. Even when they are relatively clear, professional standards may not be efficient or suitable for all purchasers under all conditions. Having emerged in a market distorted by third-party financing, the standards of customary medical practice do not adequately reflect marginal trade-offs between benefits and costs. Moreover, professional standard-setting organizations have no incentive, nor are they likely voluntarily, to set economizing standards. Because cost considerations are not weighed very heavily in medical decision making at any level, Americans consume more medical services of doubtful value than they would buy if they had good information and unrestricted opportunities to economize.

Problems similar to those encountered by private purchasers are also encountered by public programs, which can anticipate being required by courts to cover everything that does not clearly fall outside the liberally construed boundaries of accepted medical practice. In addition, providers have a powerful claim to have everything that they might be required to do under malpractice law covered by the program whose beneficiaries they are treating. Finally, political pressures may make government reluctant to give its beneficiaries any less coverage than is the norm in the private sector.

In short, the legal climate is quite inhospitable to economizing that departs in any way from standards developed or espoused by physicians having no regard for the costs to be incurred.

New Ways of Specifying Patient Entitlements

Mr. Chairman, it should be possible for private and public health plans to avoid having the rights of patients and the obligations of health care providers and payers specified, in the last analysis, by the courts. In my view, explicit language articulating alternative entitlements and obligations could be incorporated in private contracts and in the terms of public programs. Although there would be questions concerning the enforceability of contracts that seemed to derogate from patients' common law tort rights or to deny needy patients the benefit of state-of-the-art medical care, these problems could, I think, be overcome by major efforts to ensure that the economizing undertaken is rational and is explained to, and is ultimately in the interest of, the consumers affected. Private purchasers have far to go, however, in discovering effective ways to specify precisely what they do and do not want to purchase from health care providers on a prepaid basis. Public programs too have only begun to explore ways of defining limited benefit packages. The State of Oregon, however, is making a notable effort to discover how to limit what it will pay for in order

that it can provide at least adequate benefits to a larger number of beneficiaries than the state could afford to cover under a traditional plan bound by professional norms and standards.

In my view, the legal rights and remedies of patients who are injured by medical malpractice should be subject to advance modification by the express terms of a private contract. For example, a private contract limiting plan subscribers' tort damages or other rights (in the same way that some states have limited such rights by legislation) should be enforceable as written unless some clear overreaching has occurred. The legal system currently governing medical malpractice is very costly to administer, distorts medical practice in costly ways, and does not optimally serve the interests of all consumers. Just as the medical profession should not be the final arbiter of the standards of medical care, the legal system's prescriptions of patients' legal rights should yield to consumer choice, reasonably exercised. Public programs should also be in a position to confer legal protections on providers treating program beneficiaries according to program rules. Among the acceptable alternative arrangements for compensating patient injuries should be mechanisms that eliminate the fault element and pay for certain injuries automatically, thus reducing legal costs and making funds go further in compensating injured persons.

Public policy could facilitate well-considered contractual and statutory modifications of particular consumer/provider/payer relationships in several ways. Major public and private efforts are already being made to supply decision makers at all levels with better information on medical effectiveness and with validated practice guidelines. Depending upon the form that practice guidelines take and whether reliable alternative (competing) guidelines are available, consumers and taxpayers (and their agents) may soon have available to them, for the first time, a practical means of choosing and specifying in advance the precise services that they do and do not wish to purchase from providers on a prepaid basis. Government or private certification of guidelines that meet minimum standards for objectivity, scientific grounding, and disclosure of the judgments made in creating them could supply essential reassurance and valuable protection for consumer and beneficiary interests. Courts should then be willing to enforce limits in public and private plans that result from incorporating such guidelines by reference. Publicly supported and other noncommercial efforts to design and validate these and other innovative ways of specifying patient entitlements would greatly improve the chances that courts would acknowledge their legitimacy and allow economizing to proceed.

Although one can certainly visualize many difficulties that must be overcome before health care choices can be effectively

decentralized and judicial regulation can be circumvented, I believe that private contracts and reforms in individual public programs can ultimately structure health plans that economize sensitively with patients' essential needs and physicians' sensibilities in view. Whereas many current economizing efforts merely shift costs to insured patients or exclude certain services categorically, practice guidelines incorporated in health care plans could make such plans much more selective in the many grey areas of medical practice. Once guidelines are developed with appropriate care and in appropriate detail, they could implement a relatively consistent plan policy toward risk and cost across the entire range of beneficiaries' medical needs. They could thus provide not only well-conceived specific standards but also reference points for interpolating standards to govern in situations that were not anticipated. Contracts could also spell out a process by which either guidelines or other, more general standards (e.g., the standard of "medical necessity") would be applied by utilization managers in cooperation with physicians in particular cases. Well-designed procedures would go far toward legitimizing economizing decisions affecting the treatment of individual patients. I predict that the experiment in specifying basic Medicaid benefits that is currently under way in Oregon will finally succeed only after guidelines are available to permit more sensitive and selective exclusions from coverage and only after more attention is given to how such exclusions will be administered.

The suggestion that all future medical exigencies could be anticipated and provided for in practice guidelines incorporated in binding patient contracts or in entitlements under public programs will strike some people as unrealistic. But real-world relationships should be amenable to explicit restructuring with new, administrable mechanisms for coping with cost issues. Contracts of the kind known in law and economics as "relational contracts," instead of rigidly defining and anticipating every detail of the parties' future relationship, supply a basic structure that can accommodate unpredictable events and facilitate adaptations that further the parties' mutual long-term purposes. Private efforts must be made, with government support, to design contractual relationships of this character in recognition that medical progress and other exigencies can never be fully anticipated by contractual language. It should also be possible to redesign public programs to foster cooperation rather than confrontation.

What Congress Might Do

Now, Mr. Chairman, I want to address what Congress might do to expand the practical and legal limits of private contract as a vehicle for reforming American health care. In this connection, I want to call the committee's attention to a malpractice reform bill recently introduced by Senator Domenici. That bill (S. 1232) is most noteworthy for attempting to force all malpractice

litigation out of the courts and into alternative forums of dispute resolution. Although coercive in this respect and in the limits it imposes on collectable damages, the Domenici bill is in every other respect an explicit invitation to private contractual reforms of patient rights and providers' obligations. Among other things, it allows the parties to choose in advance (from a list of federally certified services) the dispute resolution service that will handle any future claims. Moreover, instead of prescribing the procedures that must be followed in resolving a dispute, it allows a service and the parties to agree to whatever procedures they wish, including procedures especially designed to resolve the particular dispute. Such freedom of choice ensures that there will be innovation and competition in providing high-quality dispute resolution at reasonable cost.

Even more significantly, the Domenici bill expressly contemplates that private health care plans might adopt a standard of care different from the one prescribed in state law; it would also allow plans to specify contractually the qualifications of expert witnesses who may testify concerning an alleged breach of the applicable standard. By writing an explicit standard of care into their contract, the parties could avoid being bound by the law's vague and inefficient standard. They might also incorporate specific practice guidelines into the contract as the agreed-upon specification of the obligations of the payer and the participating providers and of patient entitlements. If practice guidelines eventually become usable in this manner, the parties will no longer be forced by their inability to define a workable alternative standard of care to rely on the vague and inefficient standards that the legal system and the medical profession have together supplied to govern their relationship. Responsible economizing, acutely sensitive to difficult benefit/cost trade-offs, will finally be possible.

The Domenici bill also expressly contemplates that the parties to a particular health plan might choose, by contract, to substitute a no-fault compensation arrangement for traditional tort remedies for untoward events. Because the fault standard is so costly to administer (at least 60% of the money paid in as liability insurance premiums goes to lawyers and insurers rather than to injured patients!), a compensation system that omits the determination of fault in every case could be much more satisfactory for patients and could actually strengthen providers' incentives to maintain the quality of care (in order to minimize the incidence of compensable injuries). These goals are fostered in the bill by a requirement that the Secretary of HHS certify that any no-fault plan that is implemented meet certain baseline standards.

Enactment of the Domenici bill (or similar legislation inviting contractual reforms while also ensuring that the economizing measures introduced will be responsible ones) would

go far toward legitimizing private initiatives that courts are now too inclined to view with suspicion. As the private sector gains experience with such reforms, public programs will be able to emulate private choices in the grey areas of medical practice. Although it might be thought necessary to enact legislation expressly immunizing physicians who comply with contractually specified standards or practice guidelines, I would prefer to put the burden on those developing innovative plans to do so in ways that persuade courts that consumer interests were adequately consulted and protected.

Mr. Chairman, let me offer a final suggestion that some of the committee members might find constructive. I believe that there is a need to educate the public concerning the legitimacy and appropriateness of aggressive economizing in the purchasing of health care. In my view, what is needed is a highly visible public body -- I have in mind a presidential commission comparable to the commission on ethical issues in medicine that was appointed by President Carter and served until 1983 -- that would undertake a series of functions. Let me list the tasks that I would set for this commission (with some effort and poetic license, I have contrived to make them rhyme):

--publicize and educate
--operationalize and facilitate
--legitimize and validate

(1) "Publicize and educate." Here I have in mind publicizing specific opportunities to economize in the purchasing of health care and educating the public to seek value for their dollars. There is a great deal to be done and a great need to go beyond merely educating physicians and health plan executives. Ultimately, it will be necessary to reach the workers themselves and those who directly represent their interests. The goal should be not so much to help individuals choose for themselves as to help them appreciate the need for choices, to influence those who choose on their behalf, and to understand and accept economizing choices once they are made.

(2) "Operationalize and facilitate." It is not enough to show the theoretical potential for economizing. There is also a need for tools that can be used in making and implementing economizing choices. Among these tools, I would include practice guidelines. There should be, not just one alternative, but a number of options from which consumers and taxpayers (and their agents) can select the style of care that best fits the circumstances. The commission should also identify statutory and other legal barriers to responsible economizing.

(3) "Legitimize and validate." The commission should strive to ensure that economizing strategies are not frustrated by courts seeking only to avert possible hardships to individual plaintiffs. This could be done by clearly establishing and demonstrating the legitimacy of economizing choices that might be embodied in contracts or other plan specifications. If courts

see the logic of the limits imposed and the conscientiousness with which they were designed, they are likely to give them due effect in litigation. It is essential that courts see an insurer's attempt to enforce an economizing measure not as unfair discrimination against an individual patient but as the implementation of one of many difficult but generally consistent choices. Courts should see that rewriting a bargain, instead of doing justice, upsets a delicate balance and imposes unwarranted costs on all consumers of health care.

The presidential commission I propose should see its mission only as making the world safe for economizing in health care, not as setting limits on economizing efforts or as forcing anyone to accept economizing measures they do not want. Thus, there is a fourth function (which, fortuitously, rhymes with the others) that the presidential commission should not perform -- namely, it should not "standardize or regulate." Other mechanisms exist for setting proper floors for public and private programs. I strongly recommend that Congress create a presidential commission having the informational and advisory task of helping consumers and others see where the most promising and safest economizing opportunities lie and the policy task of identifying legal and other impediments to the seizing of such opportunities.

PREPARED STATEMENT OF HUMPHREY TAYLOR

Mr. Chairman:

Many people who appear before Congressional Committees have a strong point of view or represent an interest group. Appropriate questions to ask a pollster such as myself are therefore "Who pays for your polls?" and "Does he who pays the piper call the tune?"

You should know, therefore, that in this country Harris has not done any polling for political candidates or parties since 1963 (when the candidate who lost to Lou Harris's client told the media, very inaccurately, that they would not have him to kick around any more).

However, 30% or more of all our revenues in the U.S. come from our work in the health care field. Our health care clients include drug companies, insurers, HMOs, hospitals, foundations, universities and federal and state government. So I should warn you I may be a hired gun for those with a vested interest in keeping the $600 to $700 billion we spend on health care growing at a rapid rate.

If I may I will try to summarize the state of public opinion on key health care issues. However, I should mention that we also have extensive data on the attitudes of employers, doctors, hospital C.E.Os, insurers, union leaders, regulators, and legislators.

WHAT THE PUBLIC WANTS

The public wants four things from the health care system: accessibility, quality, affordability and security:

People want easy access to reasonable quality care at an affordable cost, and the peace of mind that they won't lose their health insurance and that they won't be wiped out financially by their health care costs.

HOW THE SYSTEM MEASURES UP

How does the health care system measure up to public expectations on these four criteria?

On quality it does reasonably well. Most people are very or somewhat satisfied with the quality of care and the services that they use and relatively few people are dissatisfied.

On accessibility there are two different stories. On the one hand the great majority are satisfied with their own access to care. On the other hand there is a widespread and accurate perception that many people do not have health insurance and many others are underinsured. Overwhelmingly, people say that is unacceptable. Virtually everyone (97%) now believes that health insurance is a right to which everyone should be entitled, and obviously, many people don't have it -- including many working people.

On cost there is, of course, much dissatisfaction -- with out-of-pocket costs to the consumer, with the cost to the taxpayer, and with the rate of inflation.

There is much talk about the trend toward managed care -- and it is a trend. But right now the fastest trend in corporate cost containment is not the trend toward managed care, to HMOs or PPOs or case management, it is the trend toward greater cost-sharing (a euphemism for cost-shifting by employers to employees). Ironically, this trend is fueling public dissatisfaction and the demand for radical change in our system, and support for some form of government initiative on both universal coverage and cost containment.

Higher out-of-pocket costs are also becoming a considerable barrier to getting care. More than a quarter of all adults (29%) report they have put off getting some kind of health care which they believe they needed, because of the cost, during the previous 12 months.

In addition to cost, access, and quality I mentioned a fourth criterion -- security. Fear of losing one's health insurance is now a major concern. On one poll fear of losing one's insurance came up as an even bigger concern than the out-of-pocket cost of care.

I might add that concern about the lack of long-term insurance for nursing home care and home care is also increasing as the public has become better informed about what Medicare does not cover, as the number of very old Americans increases rapidly, and as more middle-aged Americans worry about their parents.

I believe that public attitudes to the health care system are directly determined by these four criteria. On three out of the four -- cost, access, and security -- it measures up badly and things are getting worse. On only one -- quality -- is the public generally satisfied. Furthermore, our research convinces me that over the next few years as the number of uninusred will continue to grow, costs will continue to rise rapidly as will fear of losing our insurance.

EMPLOYER ATTITUDES

I mentioned that we have also surveyed business employers on many occasions on health care issues. All these surveys paint a picture of employers as cranky, confused, aimless and spineless. There are some exceptions -- but not many.

They are cranky because they have seen their health care costs go up so fast by 15, 20 or even 25% a year.

They are confused because they don't understand why this is happening to them and because most of the solutions peddled to them by their insurers and benefits consultants have not worked nearly as well as they were told they would.

They are aimless in that they have few, if any, real strategies for dealing with these problems. They are more concerned to limit next year's increase through employee cost-sharing than in addressing the underlying causes of their problems.

And they are spineless in that, even when they know some of the things they should be doing, when they understand what types of managed care works best, they are very reluctant to take the somewhat tough decisions needed. Most employers are still more part of the problem than the solution.

But I'm here to talk about public attitudes.

THE SYSTEM

I talked earlier about the few factors which shape public attitudes to the health care system -- COST, ACCESS, QUALITY and SECURITY. What do people think of the system? To put it as bluntly as I can, they think it's a disaster.

Until recently, defenders of the American system argued that while our system was more expensive it worked pretty well for the majority with health insurance and that the American people were happy with it and didn't want to change it. But in the late eighties several painful truths began to be acknowledged. That our system is not only much the most expensive; the costs are going up faster here than elsewhere. That 35 million Americans have no health insurance at any one moment in time, more than 60 million are uninsured at some time over a two year period. Many of the majority with insurance are underinsured. That the numbers of people without insurance have grown every year since 1981. And that hardly anyone has adequate insurance for nursing home care.

Somehow even those unpleasant truths didn't carry much weight so long as it was believed that most people were happy and didn't want change. Now two surveys have shown that the American health care system is also exceptionally unpopular both absolutely and when compared to other countries. Harris surveys of the public in 10 countries have asked which of 3 phrases best describes their different health care systems. The proportions of the public in these countries who believe that "the health care system works pretty well and only minor change is necessary to make it work better" varies from a high of 56% in Canada to a low of only 10% in the U.S. Most Americans (60%) replied that "there are some good things in our health care system but fundamental changes are needed to make it work better," while more than a quarter (29%) felt that "our health care system has so much wrong with it that we need to completely rebuild it." The American health care system is not only uniquely expensive, it is also, along with the Italian system, the most unpopular.

THE SHAPE OF REFORM

Americans are almost unanimous -- 9 out of 10 is pretty unanimous -- in believing that fundamental reform is needed, to achieve universal coverage and better value for money. But they -- like the experts -- are much less certain what shape reform should take. The problems are pretty obvious, the solutions are not. One is reminded of H.L. Mencken's comment that "for every complex and difficult problem there is a simple solution -- and it is wrong."

Large majorities react favorably to different proposals for reform but have more difficulty in choosing between them. They support both a government-financed national health insurance, Canadian style, and also a plan with mandatory employer-provided coverage, with the government looking after everyone else (as originally proposed by President Nixon in 1973). If forced to choose between these two a plurality favors the universal government financed option, but this could change -- up or down -- as the debate develops.

As you may know, the polls have been measuring public attitudes to various forms of National Health Insurance for forty years, and support for it today is stronger than it has ever been before.

WHY THE AMERICAN SYSTEM IS SO EXPENSIVE

As you may have guessed by now, I have not always lived in New York. In my professional work at Harris I have studied in considerable detail the many ways in which the American health care system differs from those in Canada, Western Europe and Japan -- and I have written at some length on the subject.

I see no mystery whatever in the question of why the U.S. system not only fails to cover all its citizens but also costs so much more than other systems. Among the many factors unique to this country are: --

-- Our malpractice and tort system.
-- The very high administrative costs of our reimbursement system.
-- The high fees we pay doctors and hospitals.
-- The high prices Americans pay for durgs (second highest to the Netherlands).
-- Our capital spending on hospitals and equipment.
-- The number of tests and very expensive procedures we perform (of which much seems to be inappropriate or marginal).
-- The high rates of specialists to primary care physicians.
-- The amount of care we provide to patients in the last 30 days of their lives.
-- The high level of unused hospital capacity.
-- The 800 plus state mandates on what insurance must cover.
-- The level of fraud by providers and patients.
-- The absence of expenditure caps or budgets for providers or payers.

In large measure it is the high costs generated by all these uniquely American attributes which makes it so difficult to find the extra money needed to pay for universal coverage. Furthermore, I believe the public (if not the interests involved) would favor changing many of these factors.

WHY WE HAVEN'T ADDRESSED THE PROBLEM MORE EFFECTIVELY

Given this list and given all the things we report to control costs or expand coverage, why haven't we done more?

In this most democratic of countries we don't usually make major changes (on this scale) without a consensus that the changes are desirable. We need a consensus not just that we have a problem to fix, but on 3 other points as well:

-- on the causes of the problem,
-- on the solutions, and
-- on how to pay for the solutions.

To date the only consensus is that we have a problem of high costs and poor insurance coverage. The public, business, the health care industry, and doctors, all disagree on the causes of our cost problem and will therefore also disagree on the solutions. Doctors don't mind if health care costs keep on growing. They would welcome universal coverage. But they want to be left to practice medicine with less interference from government, employers and insurers. Business leaders tend to favor changes in financial incentives (and penalties) for consumers, doctors, and hospitals, to make them operate more cost-effectively. Many health care economists feel we need to limit the use of the more expensive new technologies and find a better way to ration care, (which we do now without admitting it), based on benefits and costs. The public tends to favor draconian price controls of hospitals, doctors and drugs but is opposed to substantially increased out-of-pocket costs or the overt rationing of expensive technologies.

We have a consensus that, in theory, everyone should have reasonable health insurance. The difficult part, where we still have a long way to go, is to agree on how to do that, and how to pay for it.

Having said that, the pressures to do something are mounting visibly.

There is, we have found in our surveys a growing belief that a major federal government initiative will be needed -- not because people like or trust the government but because nobody else will do the job.

HOW IMPORTANT IS HEALTH CARE AS A POLITICAL ISSUE?

One key question, of course, is how health care -- and specifically reform of the health care system -- rates as a political issue.

The answer, briefly, is that it has the potential to be a major issue but it has not yet achieved that status. Compared to the major economic issues and other social issues such as education, crime, the environment or drugs, relatively few people spontaneously volunteer health care as a major issue.

But I believe that if heavyweight political leaders want to make it a major issue they could do so.

There is a strong and growing concern about costs -- to the consumer and the taxpayers, which are likely to get worse.

Almost everyone believes that health insurance should be universal -- and the number of uninsured are still growing.

More and more people are concerned that they may not have health insurance when they need it.

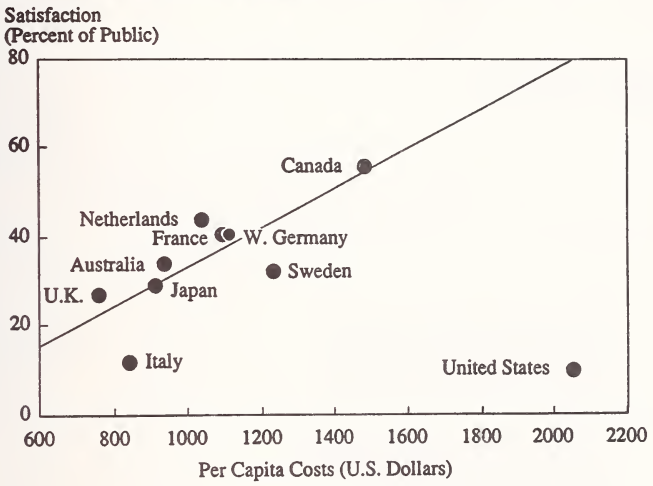
Overwhelmingly, people believe fundamental changes -- or more -- are needed.

While we do not have a clear consensus on what reform package would be best, public reactions to several alternatives are strongly positive.

If I was still in the business of advising politicians on how to run their campaigns, I would advise them that there are a lot of votes to be won by a strong health care reform bill, even if they were opposed by some powerful interests and their PACs.

Meanwhile, in the absence of substantial reform, the problems of high cost, poor access and insecurity will all get worse, all of which will make this an increasingly important issue. I fear that all of the problems will get worse -- much worse -- before Washington implements (as opposed to proposes) a viable set of solutions.

SATISFACTION AS A FUNCTION OF PER CAPITA SPENDING



Source: Harris 1988 and 1990.

TABLE 1-1A LEADERSHIP *Attitudes to Health Care System*

Q.A1a—First, a very general question. Which of the following statements comes closest to expressing your overall view of this country's health care system?

	TOTAL SAMPLE	CORPORATE EXECUTIVES	FEDERAL LEGISLATORS	KEY COMMITTEE STAFF	FEDERAL REGULATORS	UNION LEADERS	PHYSICIAN LEADERS	HOSPITAL CEOs	MAJOR INSURERS	STATE OFFICIALS
	%	%	%	%	%	%	%	%	%	%
Base:	2048	1175	260	25	15	50	201	251	21	50
On the whole, the health care system works pretty well, and only minor changes are necessary to make it work better	13	12	4	8	—	—	31	14	10	14
or There are some good things in our health care system, but fundamental changes are needed to make it work better	67	63	80	72	100	30	64	80	76	70
or The health care system has so much wrong with it that we need to completely rebuild it.	20	25	16	12	—	70	4	6	10	16
Not sure	•	•	•	8	—	—	—	•	5	—

Source: Harris and Metropolitan Life, 1990.

PUBLIC SUPPORT FOR MANDATORY EMPLOYER COVERAGE

Attitudes to "A new law which would require all employers including small businesses to provide their employees with a basic minimum level of health insurance."

	Public %	
Support very strongly	60	84%
Support somewhat strongly	24	
Support not very strongly	6	
Oppose	9	

Source: Harris 1990.

PUBLIC REACTIONS TO THREE ALTERNATIVES FOR THE FUTURE

Q.: Which one of the following plans would you like the best?

Base	1972 %	1976 %	1990 %
The present system which consists of Medicare and Medicaid, as well as coverage bought from private insurance companies by individuals, unions, and the companies people work for	30	27	19
The present system with two changes: a law requiring employers to provide health insurance to all their employees, and the government to provide health insurance to everyone who is not employed	40	38	33
A comprehensive national health insurance program covering all medical and hospital expenses paid for by federal taxes: under such a program the government would control hospital costs, physician's fees and other charges	22	27	46

Source: Harris 1990.

LEADERSHIP

TABLE 2-7A *Attitudes to Three Alternative Systems*

Q.C1—A number of plans have been proposed as ways to improve the health care system in this country. Which one of the following 3 systems would you like the best?

	TOTAL SAMPLE	CORPORATE EXECUTIVES	FEDERAL LEGISLATORS	KEY COMMITTEE STAFF	FEDERAL REGULATORS	UNION LEADERS	PHYSICIAN LEADERS	HOSPITAL CEOs	MAJOR INSURERS	STATE OFFICIALS
Base:	2048	1175	260	25	15	50	201	251	21	50
The present system, based on private health insurance, mostly through employers, plus Medicare and Medicaid	32	35	37	32	13	10	33	21	33	20
or										
The present system with two changes: A law requiring employers to provide health insurance to all their employees, and the government to provide health insurance to everyone who is not employed	43	35	35	44	60	28	61	72	67	54
or										
A comprehensive government health insurance program covering all medical and hospital expenses, paid for by taxes. Under such a program, the government would control hospital costs, physician fees and other charges	21	27	18	16	20	58	3	6	—	26
None	3	2	8	8	7	2	2	2	—	—
Not sure	1	*	2	—	—	2	*	—	—	—

Source: Harris and Metropolitan Life, 1990.

PREPARED STATEMENT OF JOSHUA M. WIENER AND RAYMOND J. HANLEY*

It is time for Americans to face a serious problem--how to organize and pay for long-term care. More and more Americans are living past age 75, 85, and even 95. Consequently, many more elderly than ever before suffer not only acute illness requiring hospitalization and a doctor's care, but also chronic disabling conditions that require long-term care either at home or in a nursing home.

Alzheimer's disease, osteoporosis, heart disease and stroke predominate among the many diseases that cause chronic disability among the elderly. These conditions bring both physical and emotional pain as many people experience and relatives watch a decline in the ability to do the things that most of us take for granted. Long-term care is the help needed to cope, and sometimes to survive, when physical or mental disabilities impair the capacity to perform the basic activities of every day life, such as eating, bathing, dressing and moving about.

The United States does not have, either in the private or public sectors, satisfactory mechanisms for helping people anticipate and pay for long-term care. The disabled and their families find, often to their astonishment, that neither private insurance nor Medicare covers the costs of long-term care to any significant extent. The disabled must rely on their own resources or, when these have been exhausted, turn to welfare in the form of Medicaid. The aging of the baby boom generation combined with rapidly falling mortality rates for the elderly will lead to sharply increased demand for long-term care that will require substantially greater public and private spending far into the next century. Before

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* These opinions are those of the authors and should not be attributed to other staff members, officers or trustees of the Brookings Institution.

additional stress is put on this inadequate system, Americans should carefully consider alternative ways of financing long-term care and what role the federal government might play in them.

Goals of Reform

The most important goal of long-term care reform is to treat long-term care as a normal risk of growing old. The costs of long-term care should not come as an unpleasant surprise causing several financial distress to individuals and families. Right now the pain and anxiety inherent in becoming disabled and in caring for a disabled relative are compounded by worries over how to pay for care. One of the great fears of the elderly is that they will be a burden on their children. It should come as no surprise that Americans highly value their independence.

With the average cost of a year in a nursing home approaching $30,000, it is long-term care--not acute care--that is the major cause of catastrophic health care costs among the elderly. Among the 1.3 million elderly with out-of-pocket costs exceeding $3,000 in 1985, nursing home costs predominated.[1] Fully 83 percent of their out-of-pocket costs were attributable to nursing home care. Even when nursing home patients do not end up on Medicaid, long-term care still imposes a substantial financial burden that can financially cripple them and their relatives.

The desire to protect the elderly against the financial burdens of long-term care embodies two quite distinct goals. One is to prevent the elderly from having to use up all of their life savings simply because they end up in a nursing home or need extensive home care. Thus, the

current long-term care system contrasts radically with the principles of the Medicare program, where virtually no one has argued that the sick or even terminally ill should deplete their assets to pay for their care. This goal is of primary importance to the middle class and above who have significant assets to protect. Although highly rated by the elderly, this is probably one of the most controversial of long-term care financing goals. While granting problems with the current system, some question whether protecting financial estates to be passed on to adult children is an appropriate public policy goal. What are savings for, they ask, if not for needed care toward the end of life?

A separate but related concern is to prevent elderly people who have been financially independent all of their lives from having to depend on welfare--Medicaid--with all its indignities and stigma. While about 35 percent of all nursing home discharges are people who are Medicaid eligible at the point of admission, an unknown but probably high proportion were not Medicaid eligible in the community.[2] This group probably had low levels of assets but too much income to qualify for Medicaid had they continued to live in the community. However, the high cost of nursing home care made them eligible for Medicaid immediately upon entry to the nursing home. Although little data is available on this issue, Burwell and others found that while only 25 percent of Michigan Medicaid patients spent down after entry to the nursing home, another 35 percent did not enroll in Medicaid until the time of nursing home admission.[3] In other words, 60 percent of the Medicaid nursing home patients were not eligible for Medicaid prior to admission to the nursing

home.[4] Presumably, the group that was not Medicaid eligible in the community but becomes so immediately upon entry to the nursing home is the middle class and below with low levels of assets. In our view, this group has not received enough attention in reform proposals.

Reform of the financing system should also aim at creating a more balanced delivery system by expanding home care. Most disabled elderly are at home and want to stay there. Paid home care services, such as home health care, homemaker help, personal care, meals-on-wheels, respite care and adult day care, help them to do so. Only a minority of the chronically disabled elderly, however, receive any formal care services. In 1982, only 25 percent of the 4.7 million disabled elderly living at home were using any paid in-home care.[5] Even among the severely disabled--those with two or more problems with the activities of daily living--only 33 percent used paid care. Instead, the vast bulk of care is provided informally by family and friends, often at great personal cost to the caregiver.

Public expenditures for long-term care for the elderly are overwhelmingly for nursing home rather than home care. In 1988, only about a quarter of government long-term care expenditures for the elderly went to home care services.[6] Although coverage of nursing home care by private long-term care insurance policies has improved markedly over the last few years, home care benefits remain fraught with restrictions and are still only modest expansions beyond existing Medicare home health benefits.[7]

Nonetheless, there is strong interest in more home care. A 1988 nationwide poll by Louis Harris found that 87 percent of the people polled favored a federal program that provided home care.[8] Similarly, in a marketing study of private long-term care insurance, when respondents were asked to choose between a cheaper policy that covered only nursing home care and one that was 50 percent more expensive but also covered home care, nearly two-thirds chose the more expensive plan.[9]

Finally, the financing system should aim to improve the quality of care provided in nursing homes and by home care agencies. While there are numerous high quality long-term care facilities, some nursing homes provide fair or poor quality care and most provide relatively mediocre care.[10] In those providing inadequate care, some of the instances of poor care are "merely" humiliating and personally degrading; other instances are life threatening. On the home care side, the popular perception is more positive, but little is known about the quality of care.

Part of the problem of low quality care in nursing homes undoubtedly reflects low Medicaid reimbursement rates in some states. The frustration is that while very low reimbursement rates guarantee low quality care, every additional dollar spent on nursing home care produces something less than a dollar's worth of improvement in quality of care.[11] This is partly because we do not have a good understanding of what quality of care is or how to achieve it and partly because some of the additional funds may be lost to inefficiency, administrative overhead, and higher profits.

Options for Financing Reform

Although a large number of options have been proposed, the three main strategies for long-term care financing reform are to rely on private sector mechanisms, especially private long-term care insurance, liberalization of Medicaid, and expansion of social insurance to include nursing home and home care. Although these strategies are analytically separate, they can be easily combined. Indeed, any major reform of long-term care financing is likely to include elements of all three approaches.

Private Sector Mechanisms

Over the last few years the market for private long-term care insurance has grown rapidly, leading some policymakers to promote private insurance as the best way to finance protection against the catastrophic costs of long-term care at a time of government austerity. The reality is that only about 3 percent of the elderly currently have long-term care insurance in force.[12] Even under optimistic assumptions about the future growth of the market, private long-term care insurance is likely to play a modest role in long-term care financing.

Studies done at Brookings, the Employee Benefit Research Institute, the Families USA Foundation, and the Urban Institute all conclude that only a minority of the elderly can afford private long-term care insurance.[13] Some other studies have found that a higher percentage of the elderly can afford private insurance, but they have done so only by assuming purchase of policies with limited coverage, by assuming that the elderly would use their assets as well as income to pay the premiums, or

by excluding a large percentage of the elderly from the pool of people considered to be interested in purchasing insurance.[14]

Although there is room for potential growth in private long-term care insurance, projections using the Brookings-ICF Long-Term Care Financing Model suggest that only limited segments of the population will be covered by the private sector. By 2018 insurance sold to those 65 and older may be affordable by 25-54 percent of the elderly, may finance 7-17 percent of total nursing home expenditures, and may reduce Medicaid expenditures and the number of Medicaid nursing home patients by 1-15 percent.[15]

Why will private insurance have a modest role in financing nursing home and home care? First, as already noted, private insurance is so expensive that most older people cannot afford it. The Health Insurance Association of America reports that the average annual premium for the 15 best-selling policies with some inflation protection is $1,395 if purchased at age 65, rising to $4,199 if purchased at age 79.[16] Premium estimates for policies with better inflation adjustments and home care benefits are substantially more expensive than products currently on the market.[17]

Second, although coverage has improved substantially over the last few years, the financial protection provided by the products is still limited. For example, benefits are rarely fully indexed for inflation, home care is still highly restricted, and most policies do not cover very long nursing home stays or home care episodes.[18]

Third, insurers are worried because the long interval between the initial purchase and ultimate use of nursing home and home care involves

very great uncertainty and financial risk. A policy bought by a woman at age 65 may not be used until she is 85, a full 20 years later. During those 20 years, unforeseen changes in disability or mortality rates, nursing home and home care utilization patterns, inflation in service costs, or the rate of return on financial reserves can dramatically transform a profitable policy into an unprofitable one.[19] Such uncertainty will likely lead insurers to limit the number of policies they sell.

While private long-term care insurance can and should play a larger role than it does now, it is not a panacea. Private insurance will not prevent public expenditures for long-term care from increasing substantially over the next 30 years, nor will it provide financial protection for the great majority of elderly.

Medicaid Reform

The principal argument for staying with Medicaid as our primary public program for financing long-term care is that despite its many deficiencies, the program is not the worst of all possible worlds. Moreover, it meets the most urgent needs of the low-income disabled population at minimal costs to taxpayers. The spend-down requirements ensure that Medicaid finances only that part of the care that is beyond the resources of the elderly. While targeted to the poor, Medicaid also provides a safety net for middle-income people with high long-term care expenses. The institutional bias ensures that persons receiving publicly financed care are predominantly the severely disabled and those without

family support. Home care services, though not as widespread as many would like, are moderately available. And, finally, the entitlement character of Medicaid means that expenditures tend to rise with need and are not limited arbitrarily by the appropriation process.

Many reforms would improve the Medicaid program, while retaining its basic means-tested, welfare character. Desirable changes include expanding home care services, increasing the personal needs allowance and level of protected assets for nursing home patients, raising the amount a Medicaid patient's spouse is allowed to retain for living expenses, and increasing reimbursement rates. All of these reforms were recently proposed by the Pepper Commission.[20]

Although incremental improvements in Medicaid are attractive and should be enacted, two basic problems remain in relying exclusively on a welfare-based reform strategy. First, public charity always carries some stigma, and efforts to reduce taxpayer costs--which are certain to rise in the future--are likely to perpetuate a two-class system with inferior access and status for Medicaid patients. Because Medicaid pays nursing homes so much less than do private patients, Medicaid patients have a much harder time gaining access to beds.[21] Moreover, most people who enter nursing homes end up on Medicaid.[22] In other U.S. welfare programs, such as Aid to Families with Dependent Children and Supplemental Security Income, only a small minority of the population is expected to be financially eligible. It is odd to structure a program so that most people needing services end up on welfare.

Social Insurance: Adding Long-Term Care to Medicare

A final option would be to cover at least part of the costs of long-term care under a social insurance program like Medicare. Under such a program, everyone would pay into the social insurance program and earn the right to benefits without having to prove impoverishment. In our view, social insurance should be a key component in any effort to reform long-term care.

There are several advantages to this approach. First, as with Social Security and Medicare, this approach would guarantee near-universal coverage. Private insurance will always exclude both those who cannot afford it and those who fail the tests of medical underwriting. Second, the costs can be spread over the largest possible revenue base, reducing the financial burden on any one individual.

Third, public insurance also offers some advantages in the way long-term care services are delivered. While not completely eliminating the two-class system, public insurance will greatly reduce the access and quality gaps between private- and public-paying patients that exist under our current Medicaid-dominated public system. Moreover, public insurance can create a more balanced delivery system by expanding home care.

An additional advantage is that public insurance can be financed in a way such that upper income people pay more than lower income people. While not meeting a strict definition of progressive taxation, there is a lot of hidden income redistribution in the payroll financing of the Medicare program. For 1991, a $100,000 a year employee will pay five

times in taxes what the $20,000 a year worker pays for exactly the same Part A benefits.

The primary disadvantage of public insurance is that all of the proposals cost a lot of money. For example, the relatively modest social insurance recommendations of the Pepper Commission were estimated to cost $30 billion a year in new federal spending.[23] Given the current system's heavy reliance on private payment, there are no "nickel and dime" public long-term care insurance solutions. The combination of an intractable budget deficit combined with a "read my lips" resistance to new taxes makes this sizeable expense a formidable barrier. The other potential problem is that public insurance may be perceived as more rigid and bureaucratic and thus not providing consumers with the choice inherent in a competitive private insurance marketplace.[24]

Social Insurance: Not Worth the Cost?

Despite the compelling arguments for social insurance as a way of reforming the financing and delivery of nursing home and home care, opponents of public long-term care insurance argue that the marginal cost to society of such a program will outweigh the marginal benefits. Some of these arguments are:

It is generationally inequitable. Proponents of generational equity contend that it is unfair to have another program that benefits the elderly which is financed mostly by the nonelderly. They contend such an approach is unfair to the nonelderly population because allocating more federal resources for a new elderly entitlement program will leave

insufficient resources for pursuing other worthwhile societal goals like improving education for children. Central to this new view of social policy is the observation that the financial status of the elderly has improved markedly while the rate of poverty among children has grown substantially.[25] Advocates of this view point to the growing proportion of elderly in the population, the declining relative size of the work force and the impact of the federal debt on the country's economic future to conclude that later generations will not even be able to shoulder the financial burden of current programs for the elderly.

There are at least four ways to respond to such generational equity concerns about social insurance for long-term care. First, most proposals, like the Pepper Commission's include the nonelderly as well as elderly populations as beneficiaries. Although disability rates are much higher for the elderly, close to half of the community-based disabled are under age 65.[26] Second, because family care is the backbone of community-based long-term care, middle-aged caregivers will benefit from an expanded federal home care program. While most research suggests families will continue to provide almost as much care as they would have without publicly-paid home care services, family caregivers will receive needed respite and benefit from being able to arrange their hours and tasks more efficiently.[27] Third, generational equity concerns are based on a narrow, cross-sectional perspective of benefits and tax payments at one moment in time rather than over a lifetime. Like the long-term benefits of public education for children, social insurance for long-term care is a response to a need that exists across the course of life and

thus benefits all groups. Indeed, the current nonelderly population is likely to live much longer--and need more long-term care--than the current generation of elderly. Finally, it is politically naive to assume that reduced spending on the elderly will automatically be converted to increased spending for children.

It costs too much. It is true that a public long-term care insurance program will be expensive. However, most of the costs of the program will be incurred by society with or without such a program and will surely be incurred if there is widespread purchase of private insurance. Both public and private insurance are subject to the same cost increasing factors, although public insurance will incur far lower administrative costs. The real issue is not whether society can escape these costs because it cannot without turning its back on the disabled. The real questions are whether costs are going to be borne largely by the relative few who end up in nursing homes or needing extensive home care or whether they are going to be spread more broadly over society as a whole and what should be the balance between public and private programs.

It will cause a tax revolt. The United States has one of the lowest tax rates of any of the industrialized countries.[28] Politicians are regularly elected and defeated based on whether or not they promise to reject new taxes. Opponents of public insurance often argue that there is some fixed level beyond which Americans will not tolerate new taxes. Thus, increasing taxes for long-term care "uses up" available taxing capacity that might otherwise go for deficit reduction or services for the poor.

While Americans do not like to pay taxes, numerous public opinion surveys have found a large number of problems--including long-term care, education, drug abuse treatment, and protecting the environment--that voters say they would be willing to pay additional taxes to address.[29] People want to see tangible benefits for their additional tax dollars. Programs primarily for the elderly, such as Medicare and Social Security, command enormous public support.[30]

Health care for the uninsured is more important. There are very strong public policy and moral reasons to address health care for the uninsured first, before long-term care. It is a scandal that there are 37 million people with no health insurance at all.

The political problem is that public opinion surveys consistently show that people are more willing to pay taxes for a public long-term care insurance program than for health care for the uninsured. In a national survey of voters sponsored by the American Association of Retired Persons and the Families USA Foundation, 57-70 percent of respondents were willing to pay additional taxes for long-term care ranging from $120 to $720 a year depending on income.[31] Yet in another national survey, less than 20 percent of respondents were willing to pay more than $51 a year to address the problem of the uninsured.[32] This political reality was reflected in the votes of the Pepper Commission.[33] The plan for health care for the uninsured squeaked by with a vote of 8-7, while the long-term care proposal sailed through by a vote of 11-4.

The logic of these paradoxical positions is explained by the basic American principle: What's in it for me? Although private health

insurance market is deteriorating rapidly, the fact is that 85 percent of the nonelderly population already had acute health insurance in 1988.[34] For the overwhelming majority of people, lack of insurance is somebody else's problem. Appeals to altruism are usually necessary to justify people paying more in taxes to solve this problem. The situation is totally reversed in long-term care. Since almost no one has insurance coverage, expanding long-term care provides new benefits to virtually everyone.

Given these political dynamics, there is a real possibility that we may never solve the problems of health care for the uninsured and, thus, never get to long-term care reform. Frankly, in the current environment, neither issue is likely to get very far without the other. Only when health care for the uninsured and long-term care are joined together will there be a big enough political constituency to get major programs passed for either.

Public insurance will provide benefits to the upper-income elderly. By definition, social insurance provide benefits for all people without regard to income. Thus, it is unarguably true that a long-term care insurance program will provide some benefits to the upper-income elderly. To some, this makes social insurance hopelessly unfair.[35]

Upon closer examination, this problem turns out to be small, remediable and a source of political strength. First, the amount of resources that will go to the upper-income population has been overstated. Long-term care is used principally by the very elderly, disabled population. This population is extremely modest in its income and assets.

For example, among the elderly age 75 and over, 48 percent have incomes below 150 percent of poverty.[36] Moreover, nearly 60 percent of the disabled elderly living in the community have incomes below 150 percent of poverty.[37]

Second, to the extent that a public insurance program does redistribute income to the upper income population, it should be recouped through the tax system. Programs should not, in net, take from lower-income workers to give to upper-income elderly. Taxes to support public insurance should be at least fully proportional if not progressive in nature. This will guarantee that the upper-income population will pay more, at least in absolute terms. Moreover, almost all elderly should pay something and more well-to-do elderly should pay more. Since public insurance will almost certainly provide some asset protection, raising the estate tax or taxing capital gains at death are particularly attractive financing mechanisms. Both of these taxes would disproportionately affect the more well-to-do elderly.

Third, including both the poor and the rich has been the key to the political successes of the Medicare and Social Security programs and would probably be essential to maintaining support for a long-term care program. Medicaid's political problems are directly related to the fact that it is a welfare program.[38] Including all income groups could also form an important constituency for improving quality of care in nursing homes and home care.

Program Design Issues

If at least part of long-term care is to be financed through a social insurance program, many questions remain on how the program benefits should be designed and administered. In several aspects, it is critical that a public long-term care insurance program should diverge from the traditional social insurance model of Medicare and Social Security.

State Involvement

Currently, long-term care is primarily the province of the states rather than the federal government. States regulate supply and quality of care, set reimbursement rates and process the claims of nursing homes and home care agencies. States also pay almost half the costs of Medicaid.

All of the major social insurance proposals to date--including those of Senator Mitchell, Senator Kennedy, Representative Waxman, Representative Stark, and the Pepper Commission--prescribe limited roles for the states. All of these proposals depend on states for administration, but exclude them from policymaking and financing. While such an approach is a natural extension of the current Medicare and Social Security programs which have no role for states, it would be a grievous mistake in long-term care.

Failure to include the states as a full financial partner will convert any public insurance program into a federal-funds maximization project. That is, states will have a strong incentive to make sure that as many people receive as many services as possible. They will also have little reason to control the supply of services. Requiring states to incur some

of the costs and the risks of a public insurance program will necessitate giving them a role in policymaking. While this raises the spector of creating the interstate variations that plague the Medicaid program and will undoubtedly complicate the decisionmaking process, the alternative creates an inefficient system.

Expenditure Controls

Efforts to pass public insurance programs for long-term care have failed largely because of the strong fears of policymakers about the costs. Policymakers have two concerns. The first concern is over the absolute level of expenditures required. As indicated above, all public insurance programs will require substantial additional public expenditures. The second concern is the uncertainty over the estimated expenditures. There is a strong fear that however honest the estimate is, it will be too low. No policymaker wants to wake up one day and find out that the actual costs of the program are twice what was originally estimated. Part of the folklore of health policy discussions in Washington is that the costs of Medicare and Medicaid turned out to be far higher than initially calculated. The constant upward revision in the estimated costs for the Medicare Catastrophic Care Act of 1988 hastened the demise of that piece of legislation.

This concern is not unwarranted. Most disabled elderly who might "medically qualify" for paid services do not currently receive any.[39] The reluctance of the elderly to enter nursing homes, however, reduces the likelihood of a large increase in nursing home use. But the inherent

desirability of some home care services--such as homemaker and chore services--means that their use is likely to increase substantially if covered by public insurance. Moreover, the principal effect of public (or private) insurance is to reduce the net cost of a service. People tend to buy more of a service when it costs less out-of-pocket.

While uncontrolled increases in the demand for long-term care have been a persistent worry for policymakers, it is difficult to know the extent to which this potential for increased demand will come to pass. Some provinces in Canada, for example, that pay for long-term care through social insurance systems have not found use to increase to unacceptable levels.[40] In addition, national cost estimates based on the Channeling demonstration experience, where home care services were essentially free, are quite modest--in the range of $8 billion in 1989 if the program were limited to the elderly with two or more problems with the activities of daily living.[41] Long-term care use within the social health maintenance organization demonstrations, which provide long-term care on an open-ended, private entitlement basis, has not been excessive.[42] Indeed, few individuals reach their relatively low benefit ceilings.

Despite the uncertainty as to what will actually happen, the anxiety about potentially runaway costs is so high among policymakers that very strong cost control mechanisms must be put in place. These should include limiting the eligible population to the severely disabled, case management, cost sharing, providing services through prepaid, capitated arrangements (e.g., social health maintenance organizations), limits on

expenditures per person or per month and strict prospective reimbursement systems.

Finally, although most of the policy discussions about long-term care reforms have been within the context of open-ended entitlement programs like Medicare and Medicaid, an explicit cap on total long-term care expenditures would come close to guaranteeing that spending did not exceed a set amount. Although universal access operating within an appropriated budget is a common approach to health programs in Europe and Canada, Americans have little experience with the concept. Opponents of this approach fear that once capped, expenditures will not rise with inflation, changing demographics or the determinants of need.[43] These reservations are serious ones, but policymakers are so frightened by the expenditure uncertainties that it is questionable whether a bill can ever be passed without a strong mechanism to limit the overall financial risk.

Front End/Back End/Comprehensive Coverage

Several specific proposals have been introduced to expand Medicare to include public long-term care insurance.[44] One option proposed by Senator George Mitchell would cover home care with a modest deductible and coinsurance, but only provide public nursing home insurance for those with lengths of stay longer than two years. The assumption is that insurers will offer and the elderly will buy insurance to cover the two-year deductible period.

This approach would have the government pay the truly catastrophic costs of very long stays, a role that many feel is appropriate.

Relatedly, recent analyses suggest that Medicaid spend-down is largely a problem of long-stay patients.[45] This approach is, however, a very high risk strategy. Even with shorter periods of coverage, private insurance remains very expensive. At age 65, a high quality product covering two years of nursing home care and fully indexed for inflation would cost over $1,000 a year per person.[46] If the supply or demand for insurance is not what is assumed, then the program fails because nursing home residents will face $60,000 in out-of-pocket costs before receiving any public insurance benefits.

A second option, proposed by former Social Security Commissioner Robert Ball and by Senator Edward Kennedy, would cover comprehensive home care but only six months of nursing home care. The Pepper Commission has proposed a similar approach, with the exception that just three months of nursing home care would be covered. The rationale is that, in a time of limited public resources, we should concentrate incremental public expenditures on patients who have some chance of going home from the nursing home or staying in the community. In this regard, it is important to note that the long-stay patients targeted by the Mitchell approach are mostly discharged dead, whereas a substantial proportion of short-stay patients are discharged alive to the community.[47] Since about half of nursing home patients have lengths of stay of less than six months, this option completely covers a substantial percentage of nursing home patients. On the other hand, the total number of days covered under this plan is relatively low. This makes this approach the least expensive. While by no means providing total protection against the huge out-of-

pocket expenditures associated with very long nursing home stays, even short stays mean out-of-pocket costs that would universally be regarded as catastrophic by any standard if they had occurred as a result of acute care expenses.

A third strategy, comprehensive coverage, has been introduced in two forms by Representative Henry Waxman and by Representative Pete Stark. Both bills cover comprehensive nursing home and home care after a relatively short deductible and with moderate coinsurance levels. This approach provides the advantage of establishing a single payer and thus enables the government to control payment rates and how services are delivered. The costs of a comprehensive program would be by far the highest of all the public approaches, and there is a greater possibility of a rigid, bureaucratic administrative system.

Medicaid reform is a necessary complement to all but the most comprehensive public long-term care insurance program, but is usually not fully appreciated how much Medicaid reform can cost. The Pepper Commission proposed substantially raising Medicaid reimbursement rates, dramatically raising the level of protected assets, substantially raising the personal needs allowance, etc. This amounted to $13 billion, 30 percent of the incremental cost of the full proposal.[48] These improvements substantially narrow the difference in costs between the Pepper Commission's proposal, which has a very limited nursing home social insurance benefit, and a comprehensive program. Based on our previous work, the incremental costs above the Pepper Commission proposals of going to a comprehensive program should be in the order of $5-10 billion.

What Should Be Done?

Major new initiatives are needed in both the public and private sectors to improve financing of long-term care. Americans need to recognize that long-term care is a normal risk of growing old, one that requires anticipation and planning. A large and virtually untapped market awaits private insurance. Continued development of that market by the private sector, with encouragement from the government, could make long-term care more affordable for a substantial fraction of the population. However, even with maximum likely development of private options, public spending for long-term care will continue to increase rapidly for the foreseeable future. As a result, improvement of public programs will remain a crucial component of any reform effort.

In general, the strategy set forth by the Pepper Commission of including home care and front-end nursing home coverage under social insurance, liberalizing Medicaid and leaving a substantial role for the private sector to provide asset protection for the upper-middle class and wealthy elderly makes sense. It seems to best balance the competing strategies, both programmatically and politically.

The issue of long-term care reform is likely to become increasingly prominent over the next ten years. For one thing, the population aged 75 and older will grow 25 percent by the year 2000. Even more important, virtually all of the parents of the baby boom generation will be elderly; thus baby boomers will have to face long-term care as a real life, intensely personal problem, no longer just something to read about in

Newsweek. The combination of the elderly and their adult children will make long-term care into a political issue that neither the president nor Congress will be able to ignore indefinitely.

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PREPARED STATEMENT OF JOHN C. LEWIN, M.D., DIRECTOR, HAWAII STATE DEPARTMENT OF HEALTH, SUBMITTED BY DR. PETER SYBINSKY

Chairman Panetta and members of the Budget Committee, I wish to express my appreciation for the opportunity to contribute to national health policy development by outlining Hawaii's innovations in this area. We have had the good fortune to innovate largely because we have lower health insurance rates and that is largely due to over 10 years of near-universal access to primary care. We deeply appreciate the opportunity and recognition you have given us by inviting us here today.

Hawaii is often thought of as a tropical paradise. Unknown is the fact that we have one of the best basic health systems in the nation. Our system delivers high-quality care for low cost, despite our otherwise high cost of living. Early intervention and outpatient treatment are emphasized but Hawaii also enjoys high-tech tertiary care programs as advanced as any state or nation. This system has resulted in very low infant mortality rates, along with the lowest death rates from such chronic illnesses as cancer and heart disease, and this is despite the troubling health statistics of our Hawaiian and part Hawaiian residents.

The key, I would hold, to our success is our state's longstanding commitment to ensuring that basic health care is available to all our people and to its innovative health care community which has experimented with ideas like short hospital stays, outpatient surgery, and preventive health programs long before they became the norm on the mainland United States.

Likewise, our state has implemented a mandated employer benefits program, the only one of its kind in the nation, has developed the third greatest number of implemented Medicaid Section 2176 waiver programs in the nation and has recently put on the road our subsidized insurance program (the State Health Insurance Program) to offer coverage to those left in the gap between these other programs. These programs are not panaceas for the national crisis of the uninsured--and we don't take them as such. But, neither are they inapplicable to the people of California, South Dakota, New Hampshire, or any other state. I've come 5,000 miles to bring you the message: We have something of value to share and look forward to working with our partner states, each of whom has something to offer, to contribute to national policy in health care.

Hawaii Prepaid Health Care Act

Let us first start off by exploring a few basics about the current structures in Hawaii's system. The Prepaid Health Care Act was adopted in 1974 to provide health insurance and medical protection insurance for most employees in the State. The Act is administered by the State's Department of Labor and Industrial Relations. This measure was passed in 1974, after many years of study and policy development. The measure was passed in a time of moderate unemployment in an environment of already strong employment-based health care coverage. Effects on unemployment have been negligible; in fact, over the last 16 years our unemployment rate has fallen to the lowest in the nation (I make no claims about a cause-effect relationship in this regard, but this seems to at least cast some doubt on assertions that such mandates will cause unemployment).

The Prepaid Health Care Law is the nation's first and only state mandated benefits plan. Virtually all employers are required to provide health insurance to their employees. Dependent coverage is optional. Costs are shared in this program. The employee pays up to 1.5% of monthly wages up to half the premium cost. The employer provides the balance. Employers may provide benefits as outlined in the Act on a self-insured basis but are still subject to the requirements that those services be provided. Two basic plans are available, a fee-for-service plan and a health maintenance plan. The fee-for-service plan is the plan most used in Hawaii, and provides for a good package of diagnostic and treatment services with copayments and deductibles. The HMO provides a generous package of benefits; these benefits are outlined in the attached administrative rules.

Exclusions

Some of those excluded from the provisions of the Act are government employees (who have their own plan), seasonal agricultural workers, real estate and insurance agents working on commission, individual proprietorship members in small family business, and government assistance program recipients.

Employee Eligibility

To be eligible for Prepaid Health Care, employees must work at least 20 hours a week and earn a minimum amount per month. The program is administered in conjunction with temporary disability and workers' compensation insurance, so no large state bureaucracy has been created to administer the provisions of Prepaid Health Care. An employer fund exists to assist employers who cannot, because of economic limitations, provide for the cost of the insurance, and to assist employees whose employers have gone out of business or who have not provided for the insurance.

Community Rating For Health Insurance

By requiring virtually all employers to provide insurance, Prepaid Health Care has permitted health care contractors to provide health insurance rates for small employers comparable to those enjoyed by large employers. This has happened because all small business now forms a large risk pool. Adverse risks are part of the overall pool, which eliminates the need for insurance companies to individually rate employers.

The results have been extremely positive. Small business can purchase insurance at reasonable rates. Employees are covered with health insurance. Insurance companies cut administrative costs and can market to a large pool of businesses. Prepaid Health Care has provided a uniformly level field for competition in which responsible small businesses who provide health insurance are not at a competitive disadvantage relative to those who do not.

Medicaid

Hawaii's Medicaid Program services over 72,000 persons with a budget of about $220 million. It is administered by the State's Department of Human Services.

Hawaii provides Medicaid to both the categorically needy and the medically needy persons. Elderly and disabled persons with income up to 100% of the poverty level, and children under age 6 with income up to 133% of the poverty level are covered. We have chosen the option to provide coverage for pregnant women and infants with income up to the maximum allowed by statute (185% of poverty). We have also implemented the "presumptive eligibility" provision for pregnant women to encourage early prenatal care.

Hawaii Population Without Health Care Insurance

The effects of these programs, particularly Prepaid Health Care, is evident. In 1971, Hawaii had 17% of its population in the gap group and was similar in this regard to California and east coast states. The implementation of Prepaid Health Care brought about a dramatic drop in those figures in several surveys conducted at the time. Estimates of those enfranchised with health insurance range from a low of 3,000 persons to over 46,000 persons, and additional numbers of persons were provided better coverage. The Department of Health has estimated that the uninsured population in Hawaii has grown with the shrinking of Medicaid to approximately 5% in 1987-1988 when planning began for the State Health Insurance Program.

Gap Group

Definition of Hawaii's "gap group" in need of care does not encompass the entire uninsured population. We have focussed on those people who have been uninsured by public or private health care coverage programs and who are at a low enough income level where they cannot access current health care insurance. The number is estimated to be between 30,000 and 35,000 people.

Populations at risk in the gap group are largely made up of those who, for one reason or another, lack access to Prepaid Health Care. As found in a 1988 survey, the unemployed make up over 30% of Oahu's uninsured. This is likely also true of the neighbor islands. Dependents of low-income workers, particularly children, are another major gap group. Part-time workers, excluded from Prepaid Health Care, are another population at risk. Neighbor island residents, immigrants, seasonal workers and students are also at risk, although they are not formally excluded from Prepaid Health Care.

State Health Insurance Program (SHIP)

To meet the needs of this gap group, the State Health Insurance Program was implemented. The program provides universal access to basic health care services to all of Hawaii's people by building upon Hawaii's Prepaid Health Care Act and Medicaid.

SHIP has been created to subsidize affordable health care coverage, encourage usage of private insurance and Medicaid and to discourage shift to SHIP from private coverage. SHIP is thus designated as a partnership between government, individuals and families, and the private sector. Through SHIP, government subsidizes insurance coverage for those unable to pay. Insurance companies provide the coverage and the already existing health care providers deliver direct care. This is essentially very similar to the model adopted by the State of Washington in its pilot Basic Health program.

Benefits

Benefits of SHIP are heavily weighted toward preventive and primary care, with health appraisals and related tests, well baby and well child care coverage and accident coverage fully covered. Twelve physician visits are allowed during the course of the year, with a $5 co-payment at the time of visit. An individual's hospitalization, however, has been limited -- up to 5 days with a dollar limit of $2,500. Two days are allowed for maternity care. As far as major exclusions, elective surgery, and high-cost tertiary care have been excluded. The program assumes that most members of the gap group will qualify for Medicaid after exercising "spend down" for these costly procedures. Waiting periods exist for some conditions.

Costs

We estimate an average State subsidy to be about $500/year with an average share for each insured to run between $75 - $100/year. The insured share is based on a sliding fee scale where individuals will pay a portion of the cost on a monthly basis and will be billed directly by the insurance company for the monthly fee. This fee scale is based upon ability to pay. Co-payment at the time of visit is $5 for all subscribers.

Table A shows the monthly fee schedule which we have adopted for the State Health Insurance Program. Note that under 100% of poverty, there will be no monthly payments and payments rise so that, at 251 to 300% of poverty, most adults will pay for the entire costs of the insurance. Health care for children is still subsidized somewhat at that level. To be eligible for SHIP, you must be a Hawaii

resident with gross income less than 300% of the poverty level. SHIP eligibility is subject to enrollment and fiscal limits and must be renewed on a yearly basis.

SHIP CARRIERS

SHIP insurance is delivered through contracts with the State's two largest insurers--Hawaii Medical Services Association (HMSA), which has about 53% of all health insurance in Hawaii and Kaiser Permanente, which has about 15% of all health insurance in Hawaii. Both have been cooperative and enthusiastic about working with us in this program.

While the RFPs were issued to all insurance companies currently providing coverage under the Prepaid Health Care statutes (over 20 companies), HMSA and Kaiser were the only insurers to provide proposals at this time. The proposals differ from one another quite significantly.

Hawaii Medical Service Association

The Hawaii Medical Service Association contract covers the bulk of SHIP's subscribers. It is a fee-for-service plan, although we do propose that in the next year of the program some sort of a managed care system be developed--if not statewide, then at least to cover major areas of the state. Over 1,000 physicians have signed on to participate in SHIP, through HMSA. This is almost one-half of all physician providers in the State. The contract is for statewide services. The insurance is as described in the Administrative Rules which have been provided to the Committee. One major facet of the insurance is that it does include a limitation of 20% of the total insurance dollar for inpatient hospitalization. We have worked with HMSA and most of the hospitals in the State to basically provide for at least some funding for inpatient care through this mechanism. We have adopted the philosophy that hospitals are providing care for this group of people already -- much of which is uncompensated. Any additional funding, even if it does not cover the whole cost of care, will be helpful to the hospitals in providing for their needs.

Kaiser Permanente

The Kaiser proposal is limited to 2,000 subscribers. Kaiser is willing to subsidize a portion of the costs of the coverage for the full health maintenance coverage for these persons, rather than cut back on services.

PROGRAM IMPLEMENTATION

SHIP was launched on April 16, 1990. Implementation was statewide. From the beginning, our objective was to eliminate the barriers and red tape which often deter the genuinely needy from getting government services.

Our major task has been to bring people into SHIP, to target what would be in any state perhaps the most difficult to reach persons, those people who are currently outside of the system. In this effort, we have emphasized the non-traditional.

First, we have shortened application forms in an effort to reduce the administrative barriers put in place by lengthy, complicated forms. These forms gather the minimum amount of information necessary to determine gross income, family size and basic information on each subscriber. Asset data is not collected. Second, we have a statewide toll-free telephone number available to persons who want to call and ask for information or application forms from SHIP. Third, certain categories of persons have instant access to SHIP, with no need to wait for SHIP's quarterly enrollment periods or less than the one-month period between enrollment and issuance of an insurance card. These persons are those dropping off the Medicaid rolls, pregnant women and children.

We have also developed a broad-based community outreach program. Over 200 volunteers have been trained to assist people filling out the SHIP application form. Our volunteers have been enthusiastic and have been drawn from both Department of Health ranks as well as the ranks of private social service agencies and other community organizations, such as the Hawaii Public Health Association. This effort has transcended our regular organizational structure and has brought together a wide range of staff to work together in this exciting effort.

We have been flexible in our outreach in terms of trying to bring the program to the people. Application forms and assistance are available in many of the Department of Health offices statewide. Our goal is to make all offices enrollment centers. Special outreach tables have been set up at supermarkets, shopping centers, health fairs and other heavy traffic situations in the State. We have enlisted the five non-profit primary health care centers on Oahu to sign up persons for SHIP. We have also sent out "teaser" brochures to all 170,000 public school students in the State. These brochures inform parents about SHIP and provide a mechanism for additional information and applications to be obtained.

To further extend our efforts, we have worked very closely with our public agency partners--the Department of Human Services and the Department of Labor and Industrial Relations--in developing a referral system from these two major mechanisms to provide clients for SHIP. The fact that our three state level departments provide in a centralized manner the health and human services which are the purview of county and local governments in other states facilitates our task. All Department of Human Services eligibility workers have been trained and are familiar with SHIP as well as many of those who provide for the unemployment insurance program in the Department of Labor and Industrial Relations. SHIP presentations are provided to the unemployed on a regular basis. Those persons who drop off of Medicaid rolls and those who enter the unemployment system are through this system provided access to SHIP.

Finally, we have developed an extensive media approach. Whether we like it or not, the media is the major way most persons receive information. We have utilized both free and paid media in our efforts to publicize SHIP. We have developed a television commercial and radio commercials in various languages which play frequently on a number of stations which have specialized listening audiences. This has kept costs down but allowed us to reach groups at particular risk of being uninsured. A SHIP video tape, 9 minutes long, has been produced and copies are available for outreach and office use. This tape describes the benefits in the plan and discusses all the basic aspects of the plan.

Print ads and bus posters have also been produced for SHIP and we issued a weekly press release giving weekend outreach sign-up locations. These have been picked up by the media and has been in the newspapers across the state every weekend thus far.

We're also part of a unique program which uses touchscreen computers to provide information and referral on state health and human services. This program entitled Hawaii Access is located at four locations on Oahu. We also have developed a module which allows people to actually apply for SHIP through this publicly accessible computer touchscreen.

What results have been realized from these efforts? Over 10,500 applications have been received by SHIP and over 11,380 individuals have been serviced. Our first application period extended from April 16 to July 7, 1990. The second application period for SHIP, which began on October 1, 1990 was extended through January 7, 1991 to accommodate the flood of inquiries and applications. As of April, 1991, we have enrolled 9,363 members aboard HMSA and SHIP and 700 in Kaiser-SHIP, which includes 115 newborns. Our first "SHIP baby" was born in Hilo, Hawaii on June 4, 1990. As expected, SHIP members are, in general, young (45.8% are under age 18). Our outreach in rural areas appears to have been successful as over 47% of SHIP clientele are from the generally rural neighbor islands. Sixty-one percent (61%) of SHIP membership has family income below the Federal poverty level, with over 95% of the membership below 200% of the poverty level. (Please see attached Tables 1 - 4 for more specifics.)

Conclusion

As a state, we are proud to be able to contribute what we can to this Committee. Rather than attempting to create a national health insurance or national health delivery system, Hawaii strongly recommends a "national health policy of benefits for all citizens to be implemented and organized by the fifty states". Cost should be shared by both Federal and State governments.

As for our own specific recommendations, Hawaii envisions implementing the nation's first seamless universal health system as a national demonstration project. We believe that we have a plan which would build on present strengths, correct weaknesses, and increase efficiency while reducing costs. Ours is a private sector model of managed competition; promoting incentives, consumer choice, private practice, and private insurance, with heavy emphasis on primary care.

Some of our recommendations would alter current Federal policies or programs which unduly inhibit state capacity for experimentation. We propose such flexibility, mindful of the memorable words of Justice Brandeis, "To stay experimentation on things social and economic is a grave responsibility. Denial of the right to experiment may be fraught with serious consequences to the Nation. It is one of the happy incidents of the federal system that a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country."

Let me apprise you of Hawaii's vision for the future:

1) Eliminate ERISA Restrictions on State-Mandated Benefits Plans

ERISA currently freezes the Hawaii Prepaid Health Care Law at the 1974 level. This impedes the growth of innovative measures such as cost containment, cafeteria plans, etc., as these would have to be developed within the parameters of the Prepaid Health Care Law. Eliminating the ERISA restriction will allow Hawaii and other states to experiment with mandated benefits and evaluate the results closely. For example, a state might wish to only mandate large employers to cover their employees and compare it with other states like Hawaii which have chosen to cover most of the employed persons within their boundaries. Similarly, the effects of various benefits packages could be studied with this increased state flexibility.

2) Reform Medicaid

The current Medicaid system is a patchwork of Federal mandates and options, linked together with heavy doses of administrative restrictions. States must wait years sometimes for waivers and changes in state plans must be approved by various HCFA offices. In order for Medicaid to be more responsive and flexible, we propose the following:

A) Allow for greater state experimentation with Medicaid delivery systems. Such options as employer buy-ins and copayments which have been outlined in the policies of the Bipartisan Senate Committee could be tried in various states. Alternatives not yet conceived nationally might find fertile ground in one state or another.

B) Reduce administrative paperwork required for Medicaid. Many administrative requirements of Medicaid actually serve as barriers to the poor, be they working poor or truly indigent. If indeed Medicaid is to be a program for the poor, it must reach them. Major reforms which allow for state flexibility in this area should be enacted.

C) Create incentives for managed care alternatives under Medicaid. Very few managed care alternatives currently exist in Medicaid programs, and none at a statewide level. Fiscal and administrative incentives to offer such alternatives would help the spread of a more cost effective and responsible methodology of care.

D) Increase Medicaid reimbursement levels for institutions and primary care providers, particularly those in areas where there is a high proportion of uninsured persons. This temporary expedient could assist institutions impacted by large numbers of uninsured.

E) Continue to create and fund Medicaid options for the states rather than to enact mandates.

3) Tort Reform

Develop a package of tort reforms on a federal level. Tort reform is essential to any comprehensive health care reform, and is extremely difficult to enact on a state by state basis, without preceding federal legislation. Such a package should significantly reduce the need for physicians to practice "defensive medicine," while providing appropriate, timely redress. Any tort reform should include caps on awards for pain and suffering, and attorney's fees.

4) Create a State or Federal Basic Benefits Package

Create a package of basic benefits, ranging from primary and preventive care services through catastrophic care; including necessary medical treatment, hospitalization, surgical and drug benefits. Through legislative enactment, these benefits would be standardized for the whole population, and they would be mandated to be a part of employer based coverage, public programs such as Medicaid and SHIP, and individual plans. These benefits would be available to all, and represent a universal minimum of basic care guaranteed each individual in our society. Insurance companies may exceed this basic benefits package, providing extra care for extra dollars.

The basic benefits package would be offered by all insurers at a fixed community rate, which would serve as a risk pool for the total population. There would be no co-payments or deductibles charged to consumers for care covered by the basic benefits package.

5) Insurance Reform

Require insurers to accept all applicants, with no waiting periods beyond the administrative processing time. All insurers must be capable of offering the basic benefits package at the established community rate, with potentially separate rating for children, adults, and seniors.

Insurers would also process all claims using a universal claim form. In an HMO setting, this would serve as an encounter form. By reducing insurance claims/encounter descriptions to the same format, we would reduce a host of administrative hassle and open utilization data for review and analysis -- except for individual identifying information.

6) Establish a Regulatory Agency to Oversee Insurance Rating and Utilization Data.

Establish an agency, a "Health Care Cost Commission," which would be governed by a board whose members would be appointed by the Governor, and representative of providers, insurers, business and labor, and consumers. The Commission would serve to:

A) Collect and analyze data from universal claim/encounter forms for all Basic Benefits Package activities, and make this data accessible to providers and insurance companies for development of cost containment activities;

B) Approve and certify rates of individual insurance companies, based upon the analysis of data;

C) Impose rate setting on the system;

D) Coordinate planning and budgeting of government, incorporating all health expenses, including public health "safety net" services; and

E) Act as the appellate body for insurers and providers on provider rates

7) Provider Reform

Provide incentives to physicians to adopt the role of "gatekeeper," managing efficient use of health care resources, including specialists and ancillary personnel. It would be the physician's prerogative to require more or less specialized care, with specialty care only available upon referral by primary care physician.

Significant incentives must be provided for physicians who provide quality care at lower costs. These could include: a case management fee for every case where the physician was the primary care physician; sharing in economic savings at the end of the year; equitable reimbursement rates for all clients, regardless of the program subsidizing care; and, coupled with tort reform, physicians could significantly reduce the volume of unneeded tasks inducted for "defensive medicine" purposes.

A significant element in this system would have to be the strong incentives for physicians to provide care to all, regardless of economic circumstances or status in a public program, because the basic benefits package would be enjoyed by all, with equitable reimbursement rates for public and private programs.

8) Reformed Public Health System

Expand the role of the private sector by shifting public sector services (such as clinic service type operations, prevention, etc.) to the umbrella of care covered by the Basic Benefits Package. This would reduce the sporadic and often times duplicative provision of "gap group" services, thereby streamlining the system. Government health agencies, service contractors, and volunteer agencies would then be able to serve as the public's safety net, exclusively providing necessary health services where there is a public need not met by the Basic Benefits Package.

Under a reformed public health system, services provided by the public sector may include:

- Specialty services to undeserved groups;
- Services such as health education, case management services for overutilizers of the system, tuberculosis control, disease control, specialized housing and rehabilitation services, and other specialized services.

9) Allow for Significant State Latitude in Program Development and Implementation

The states remain inventive and important actors in this process by developing new models and systems of delivery. By sharing this innovation, states contribute to policy development. For example, SHIP has greatly benefitted from working with Washington State's Basic Health plan. Even with implementation of Federal policies, the states should be given the flexibility to continue as major actors. Any future Federal health care legislation should be formulated on the basis that the Federal programs are safety nets and do not preempt state programs which seek to provide better benefits to their citizens. In fact, new Federal/State partnerships should be explored, such as possible joint projects for Medicare recipients. Through this principle, states can be encouraged to continue in the forefront of policy development in health care finance.

Hawaii is poised and ready to proceed with those aspects of our plan which are within our power to implement. Given the necessary federal reforms, not only could Hawaii implement all aspects of its plan, other states would also be better able to develop their own solutions. The need is there, and I believe that states stand ready to commit resources and talent toward solving the problem. Until a national consensus is reached on this issue, states must be given the flexibility to mobilize a framework for action and to develop the true experimental laboratory for public policy. From this broad base, truly responsive and workable national policy can be derived, policy that will meet the important health care needs of America's uninsured without bankrupting America.

Thank you for the opportunity to contribute our thoughts on this vital national issue.

Attachments: Prepaid Health Care Act and Related Administrative Rules
Table A - SHIP Sliding Fee Schedule
Tables 1 through 4

TABLE A
SHIP Sliding Fee Schedule

Family Members	Annual gross income under	You'd pay monthly for each Adult	Child
1	$7,224	$ 0	
	9,030	10	
	10,836	15	
	14,448	20	
	18,060	40	
	21,672	60	
2	$9,684	$ 0	$ 0
	12,105	10	5
	14,526	15	7.50
	19,368	20	10
	24,210	40	15
	29,052	60	20
3	$12,144	$ 0	$ 0
	15,180	10	5
	18,216	15	7.50
	24,288	20	10
	30,360	40	15
	36,432	60	20
4	$14,604	$ 0	$ 0
	18,255	10	5
	21,906	15	7.50
	29,208	20	10
	36,510	40	15
	43,812	60	20

TABLE 1
State Health Insurance Program
All Members by Island as of April, 1991

Oahu	52.6%
Hawaii	29.1%
Maui	8.1%
Kauai	7.8%
Molokai	2.1%
Lanai	0.2%

TABLE 2
State Health Insurance Program
All Members by Ethnic Group as of April, 1991

Caucasian	28.6%
Hawaiian/Part Hawaiian	22.4%
Filipino	11.1%
Mixed	9.3%
Korean	7.6%
Other	6.6%
Chinese	5.3%
Japanese	3.7%
Samoan	2.3%
Puerto Rican	1.2%
Unknown	1.0%
Black	.8%

TABLE 3
State Health Insurance Program
All Members by Age as of April, 1991

Under 1 year	2.2%
1-5	12.8%
6-18	30.8%
19	.9%
20-29	12.9%
30-39	17.7%
40-49	12.3%
50-59	6.0%
60-64	3.7%
65+	.7%

TABLE 4
State Health Insurance Program
All Members by Federal Poverty Level as of April, 1991

100%	61.5%
125%	13.4%
150%	9.6%
200%	10.8%
250%	3.6%
300%	1.1%

PREPARED STATEMENT OF ELAINE J. POWER, M.P.P., AND ROGER C. HERDMAN, M.D.

The Oregon Medicaid Proposal

June 19, 1991

According to the State of Oregon, up to 450,000 Oregonians, or about 18 percent of the State's population, do not have health insurance.[1] To address this problem, the Oregon legislature passed the Oregon Basic Health Services Act in 1989, which consists of three separate bills to expand access to health insurance in the State. Each of the three bills targets a specific segment of the uninsured population.

The first of the three bills, Senate Bill (SB) 27, expands the Oregon Medicaid program to include all persons with incomes up to the Federal poverty level. It also makes several other major changes to the Medicaid program, as I will describe in more detail in a moment.

The second bill, SB 534, establishes a State high-risk insurance pool for persons whose incomes are above the poverty level but who are unable to purchase insurance due to preexisting health conditions and anticipated future high health care costs. The premium charge for policies from this insurance pool are to be not more than 150 percent of the cost of an average private health insurance premium. Program costs not covered by the collection of premiums will be financed through general State funds and through mandatory contributions by private insurers.

SB 935, the third bill of the Act, addresses the problem of persons who are employed but have no employer-based health insurance. This law encourages, and ultimately requires, small businesses to provide health insurance to their employees that covers at least the level of services covered for the Medicaid population under SB 27. Businesses receive tax credits for providing insurance. They have the option of choosing private insurance plans or purchasing insurance from a State fund created for that purpose. Employers who do not provide health insurance after 1994 will be required to make mandatory contributions to the fund, but that provision is repealed if at least 150,000 previously uninsured persons receive health insurance by January 1994.

The Provisions of SB 27

SB 27 makes major changes to almost every aspect of the State's Medicaid program. As you know, Oregon requires a waiver from the Federal Government to implement this law as planned, because many of the changes that Oregon wants to make are not permitted under usual Federal Medicaid rules.

Under SB 27, the Medicaid-eligible population is expanded substantially. All State residents with incomes below the Federal poverty level will be eligible to receive Medicaid services. In contrast, at present, most people in Oregon must have incomes that are less than 70 percent of the Federal poverty level to qualify for Medicaid.[2] According to the State of Oregon, the expansion in eligibility under SB 27 will eventually add approximately 120,000 people to the Medicaid rolls.

Most of the currently eligible population that will be covered by SB 27 is made up of women and children who are eligible because they receive assistance through the Aid to Families with Dependent Children program, or because they are poor pregnant women and young children who have been made eligible for Medicaid through recent Congressionally mandated expansions. In contrast, many of the newly eligible recipients will be single adults, childless couples, and families with incomes below the Federal poverty level who could not previously qualify for Medicaid.

Certain groups currently covered by the Oregon Medicaid program are not affected by the changes in benefits made under SB 27. Medicaid eligibles who are elderly, disabled, in institutions, in foster care, or in the custody of the State are exempt from the bill. These groups will continue to be eligible for all Medicaid benefits under the current rules and will continue to receive the same services as they did before SB 27.

Reimbursement and delivery of services will also change under the new plan. Most of the population receiving services under SB 27 will be enrolled in some form of managed care reimbursed on a prepaid, per capita basis. Rural residents are excepted from this requirement and will continue to receive services on a fee-for-service basis. Reimbursement rates for both urban and rural providers (hospitals as well as physicians) are slated to increase in order to improve provider participation in Medicaid and increase access to services.

Finally, the covered services to which the Medicaid-eligible population is entitled could change dramatically. For those Medicaid recipients subject to SB 27, the covered services will be determined by a prioritized list of health services in which all health conditions and their treatments are listed in importance from highest to lowest. The State legislature then determines their budget for the program, and a line is drawn where projected program costs equal the budgeted amount. All conditions and treatments above the line are then covered; conditions and treatments below the line are not covered.

Certain services currently offered under the Medicaid program are also initially unaffected by the provisions of SB 27 and do not appear on the prioritized list. Long-term care services, for example, are excluded from the list because they are used primarily by the aged and disabled groups that are exempt from SB 27. Mental health and chemical dependency services are also currently excluded from the prioritized list, although they are intended to be incorporated into the list after 1993. Until that time, any of the group of Medicaid beneficiaries covered by SB 27, including newly eligible groups, will receive these services under current program rules.

The process for determining the final ranking of the pairs of conditions and their treatments was carried out by the Oregon Health Services Commission, which consists of a mix of providers and consumers and was established by law for that purpose. The process consisted of six steps:

1) The commission, with input from health care provider groups, grouped existing diagnostic and procedure codes into 709 condition-treatment pairs. For example, end-stage renal disease, a condition, and kidney transplant, one treatment for that condition, are a condition-treatment pair. Other condition treatment pairs are less specific--for example, medical therapy is the listed treatment for the condition of birth trauma.

2) For each pair, the commission gathered information on treatment cost, expected treatment effect on patient's quality of well-being, and expected duration of benefits. Information on treatment effects and the value of different states of health was elicited through health care providers' assessments of outcomes and Oregonians' health state preferences elicited through a telephone survey.

3) The commission ranked 17 general categories of services, such as preventive care for children and comfort care, according to their judgments as informed by societal values elicited at a series of public meetings.

4) The commission then placed each condition-treatment pair into one of the service categories.

5) Within each category, pairs were ranked according to the calculated expected net benefit of treatment, as derived from the consumer telephone survey and the provider assessments.

6) Finally, the commission reviewed the overall list in detail and selectively moved items up or down the list as deemed appropriate. In this final step, condition-treatment pairs could be moved across categories.

The Commission completed their ranking process and submitted the final list of 709 ranked condition-treatment pairs to the State legislature on May 1, 1991. The legislature is now in the midst of debating their budget and deciding where on that list of services the line should be drawn.

Oregon has a 2-year budget cycle. An important provision of SB 27 is that if the Medicaid program should suffer a budget shortfall, the program may not cut people out of the program or reduce provider payments. Instead, covered services are reduced as necessary, with the lowest-ranked services being eliminated first.

OTA's Evaluation of the Oregon Medicaid Proposal

Oregon's proposal for its Medicaid program is novel for a number of reasons. First, it explicitly separates Medicaid eligibility from eligibility for other assistance programs; if you are poor you can receive Medicaid services regardless of whether or not you meet the categorical requirements for other programs. Second, it proposes to put the majority of its client population under mandatory, capitated managed care. Both of these changes could have a substantial impact on beneficiaries' access to services.

The most striking change, however, is the method for determining what services are to be covered under Medicaid. At present, the Federal Government requires that all States receiving Federal Medicaid assistance provide a core set of services to all eligible beneficiaries. These services include such things as basic hospital inpatient and outpatient care; physician and laboratory services; and early and periodic screening, diagnosis, and treatment services for children. The Federal Government permits States to offer a broader array of optional services if they choose, such as prescription drugs and physical therapy. The current Oregon Medicaid program offers all of the mandatory services and most of the optional ones. To contain costs, however, it also has certain limits on the use of these services. At present, for example, Oregon limits adult hospital benefits to 18 days per recipient per year.

The proposed program would both define and cover services in an entirely different way. Under SB 27, diagnostic services would continue to be covered in the same manner as at present. Once a condition is diagnosed, however, coverage for any given treatment of that condition depends on whether that treatment for that condition lies above the line that defines funded services. If it is above the line, the services and products that constitute the treatment will be covered, including physician services, drugs, laboratory services, and so on.

Thus, if Oregon were to put in place the provisions of SB 27, it might have significant implications for both existing and new Medicaid recipients in the State. To examine some of the implications of the change in the delivery system, the General Accounting Office (GAO) is currently undertaking a study examining the Medicaid managed care program in Oregon. Concurrently, the Office of Technology Assessment (OTA) is undertaking a broad evaluation of the Oregon Medicaid proposal at the request of the Committee on Energy and Commerce, with a letter of support from Senator Gore. GAO and OTA are coordinating their two complementary efforts.

The OTA evaluation is focussing on two separate aspects of the Oregon proposal. First, we are assessing their prioritized list of services and the process by which that list was derived. Second, we are examining the potential implications of the proposal for Medicaid beneficiaries and for the providers who serve them. Our report from this study is scheduled to be delivered to Congress this winter. A summary describing the scope of the OTA project is attached.

References

[1] Oregon Office of the Governor, Salem, OR, "Governor Accepts Final Health Care Priority List, Moves Legislature Towards Funding," press release, May 1, 1991.

[2] Office of Medical Assistance Programs, Oregon Department of Human Resources, "Waiver Application for Oregon Medicaid Demonstration Project," discussion draft, April 26, 1990.

Summary of OTA's Project to Evaluate the
Oregon Medicaid Proposal

BACKGROUND: Expensive medical technologies, substantial and growing numbers of poor people, general health care cost increases, and tight fiscal situations in the Federal Government and many States all have contributed to Medicaid difficulties. Many States, including Oregon, have in the past responded by tightening eligibility standards for enrollment in Medicaid, thus serving only the poorest of the poor. The State of Oregon has recently proposed a major departure from Medicaid procedures. It seeks a waiver to excuse it from mandated Federal standards for State participation in the program and to put in place a new but untested system.

The proposed system would, Oregon claims, allow the State to include all eligible individuals up to 100 percent of the poverty level, but with a possible reduction in technologies and services covered, based on a system of rank ordering by medical importance of all medical conditions (diagnoses) and their attendant medical interventions (technologies and services). The costs of Oregon's paying for each medical condition and technology (intervention) would be computed and a cumulative amount, from the top (most medically important), would be compared by the State legislature to the amount of funds available for Medicaid. The legislature will then "draw a line" at the amount to be spent, and services below the line would not be paid for by Medicaid.

Oregon believes that this system will allow increased numbers of poor people to receive services and that essential services and disease prevention and health promotion services will be available and emphasized. Those skeptical about the proposal point to its untested nature, to what they term its lack of equity (elderly people and disabled people are exempted), that essentially the reduction in services will apply only to women and children, and that some essential technologies (perhaps including some technologies and services currently mandated by Federal requirements) will most likely fall below the cut-off line. Others are skeptical of the methods used to determine rankings of medical importance.

The OTA project does not directly address the concept of "rationing" in health care. RatHer, it is evaluating the mechanics of Oregon's proposed system, including a methodologic critique. A major part of the project is an analysis of evidence (from the health care literature and elsewhere) on the effectiveness of selected medical services for women and children, paying particular attention to how well Oregon's rankings reflect the medical evidence on those services. It is also analyzing the potential implications for the health status of poor women and children due to lack of access to selected technologies and services, especially those low on the Oregon rankings. The implications of the proposal for other Medicaid beneficiaries and the financial and clinical implications for health providers will be examined as well.

REQUESTED BY: House Committee on Energy and Commerce (John Dingell, Chairman) and its Subcommittee on Health and the Environment (Henry Waxman, Chairman). A letter of endorsement was been received from Senator Gore.

SCHEDULE: The assessment began in July 1990. A final draft will be submitted to Congress in early 1992.

[Whereupon, at 4:10 p.m., the Committee adjourned.]

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